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111TH CONGRESS
1ST SESSION

H. R. 3090

To improve the health of minority individuals, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 26, 2009

Mrs. CHRISTENSEN (for herself, Mr. DAVIS of Illinois, Ms. BORDALLO, Ms. ROYBAL-ALLARD, Mr. CLYBURN, Mr. RANGEL, Ms. LEE of California, Mr. HONDA, Mr. CUMMINGS, Ms. JACKSON-LEE of Texas, Ms. CLARKE, Mr. WATT, Mr. CLAY, Mr. THOMPSON of Mississippi, Mr. MEEK of Florida, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. AL GREEN of Texas, Mr. JOHNSON of Georgia, Mr. CLEAVER, Mr. ELLISON, Ms. WATSON, Mr. JACKSON of Illinois, Mr. CARSON of Indiana, Mr. TOWNS, Ms. FUDGE, Ms. KILPATRICK of Michigan, Ms. RICHARDSON, Ms. BALDWIN, Mr. FATTAH, Mr. BISHOP of Georgia, Mr. SCOTT of Georgia, Mr. PAYNE, Mr. MEEKS of New York, Mr. GRIJALVA, Mr. SCOTT of Virginia, Mr. DAVIS of Alabama, Mr. GRAYSON, Ms. EDWARDS of Maryland, Ms. MOORE of Wisconsin, Ms. CORRINE BROWN of Florida, Ms. WATERS, Ms. HIRONO, Ms. DEGETTE, Mr. FALEOMAVAEGA, Ms. MATSUI, Mr. LEWIS of Georgia, Mr. GONZALEZ, Mr. SABLAN, Mr. PIERLUISI, Mr. REYES, Mr. ORTIZ, Ms. VELÁZQUEZ, Mr. LUJÁN, Mr. HASTINGS of Florida, and Mr. CUELLAR) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, Education and Labor, the Judiciary, Natural Resources, Armed Services, Veterans' Affairs, and Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To improve the health of minority individuals, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Equity and Accountability Act of 2009''.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows:

TITLE I—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE

SEC. 101. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

(a) FINDINGS.—Congress finds the following:

(1) Effective communication is essential to meaningful access to quality physical and mental health care.

(2) Research establishes that the lack of language services creates barriers to and diminishes the quality of health care and health status for limited English proficient individuals.

(3) The number of limited English speaking residents in the United States who speak English less than very well and, therefore, cannot effectively communicate with health and social service providers continues to increase significantly.

(4) The responsibility to fund language services in the provision of health care and health care-related services to limited English proficient individ-

uals is a societal one that cannot fairly be visited solely upon the health care, public health or social services community.

(5) Linguistic diversity in the health care and health care-related services workforce is important for providing all patients the environment most conducive to positive health outcomes.

(6) All members of the health care and health care-related services community should continue to educate their staff and constituents about limited English proficient issues and help them identify resources to improve access to quality care for limited English proficient individuals.

(7) Access to English as a Second Language instruction is an important mechanism for ensuring effective communication and eliminating the language barriers that impede access to health care.

(8) Competent languages services in health care settings should be available as a matter of course.

(b) AMENDMENT.—The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following:

"TITLE XXXI—CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE

"SEC. 3100. DEFINITIONS.

''In this title:

''(1) BILINGUAL.—The term 'bilingual' with respect to an individual means a person who has sufficient degree of proficiency in two languages.

''(2) COMPETENT INTERPRETER SERVICES.—The term 'competent interpreter services' means a trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language. The interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source message.

''(3) COMPETENT TRANSLATION SERVICES.—The term 'competent translation services' means a trans-language rendition of a written document in which the translator comprehends the source language and can write comprehensively in the target

language to convey the meaning intended in the source language. The translator knows health and health-related terminology and provides accurate translations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source document.

''(4) EFFECTIVE COMMUNICATION.—The term 'effective communication' means an exchange of information between the provider of health care or health care-related services and the limited English proficient recipient of such services that enables limited English proficient individuals to access, understand, and benefit from health care or health care-related services.

''(5) GRIEVANCE RESOLUTION PROCESS.—The term 'grievance resolution process' means all aspects of dispute resolution including filing complaints, grievance and appeal procedures and court action.

''(6) HEALTH CARE GROUP.—The term 'health care group' means a group of physicians organized, at least in part, for the purposes of providing physicians' services under the Medicaid, SCHIP, or Medicare programs and may include a hospital and any other individual or entity furnishing services covered

under the Medicaid, SCHIP or Medicare programs that is affiliated with the health care group.

''(7) HEALTH CARE SERVICES.—The term 'health care services' means services that address physical as well as mental health conditions in all care settings.

''(8) HEALTH CARE-RELATED SERVICES.—The term 'health care-related services' means human or social services programs or activities that provide access, referrals or links to health care.

''(9) INDIAN TRIBE.—The term 'Indian tribe' means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) (43 U.S.C. 1601 et seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

''(10) INTEGRATED HEALTH CARE DELIVERY SYSTEM.—The term 'integrated health care delivery system' means a system comprised of more than one type of health care provider for the purposes of providing a. The providers may include hospitals, clin-

ics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent or contracted physicians.

''(11) INTERPRETING/INTERPRETATION.—The terms 'interpreting' and 'interpretation' mean the transmission of a spoken message from one language into another, faithfully, accurately, and objectively.

''(12) LANGUAGE ACCESS.—The term 'language access' means the provision of language services to an LEP individual designed to enhance that individual's access to, understanding of or benefit from health care or health care-related services.

''(13) LANGUAGE SERVICES.—The term 'language services' means provision of healthcare services directly in a non-English language, interpretation, translation and non-English signage.

''(14) LEP.—The term 'LEP' means limited English proficient.

''(15) LEP RELATED DATA COLLECTION ACTIVITIES.—The term 'LEP related data collection activities' includes identifying, collecting, storing, tracking, and analyzing primary language data, and information on the methods used to meet the lan-

guage access needs of limited English proficient individuals.

''(16) MEDICARE, MEDICAID, AND SCHIP.—The terms 'Medicare', 'Medicaid', and 'SCHIP' means the respective programs under titles XVIII, XIX, and XXI of the Social Security Act.

''(17) MINORITY.—

''(A) IN GENERAL.—The terms 'minority' and 'minorities' refer to individuals from a minority group.

''(B) POPULATIONS.—The term 'minority', with respect to populations, refers to racial and ethnic minority groups.

''(18) MINORITY GROUP.—The term 'minority group' has the meaning given the term 'racial and ethnic minority group'.

''(19) RACIAL AND ETHNIC MINORITY GROUP.—The term 'racial and ethnic minority group' means American Indians and Alaska Natives, African Americans (including Caribbean Blacks, Africans and other Blacks), Asian Americans, Hispanics (including Latinos), and Native Hawaiians and other Pacific Islanders.

''(20) ON-SITE INTERPRETING/INTERPRETATION.—The term 'on-site interpreting/interpretation'

means a method of interpreting/interpretation for which the interpreter is in the physical presence of the provider of health care or health care-related services and the limited English proficient recipient of such services.

''(21) SECRETARY.—The term 'Secretary' means the Secretary of Health and Human Services.

''(22) SIGHT TRANSLATION.—The term 'sight translation' means the transmission of a written message in one language into a spoken message in another language.

''(23) STATE.—The term 'State' means each of the several states, the District of Columbia, the Commonwealth of Puerto Rico, the Indian tribes, the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

''(24) TELEPHONIC INTERPRETATION.—The term 'telephonic interpretation' (also known as over the phone interpretation or OPI) means a method of interpreting/interpretation for which the interpreter is not in the physical presence of the provider of health care or related services and the limited English proficient recipient of such services but is connected via telephone.

''(25) TRANSLATION.—The term 'translation' means the transmission of a written message in one language into a written message in another language.

''(26) VIDEO INTERPRETATION.—The term 'video interpretation' means a method of interpreting/interpretation for which the interpreter is not in the physical presence of the provider of health care or related services and the limited English proficient recipient of such services but is connected via a video hook-up that includes both audio and video transmission.

''(27) VITAL DOCUMENT.—The term 'vital document' includes but is not limited to applications for government programs that provide health care services; medical or financial consent forms; financial assistance documents, letters containing important information regarding patient instructions (e.g., prescriptions, referrals to other providers, discharge plans) and participation in a program (such as a Medicaid managed care program); notices pertaining to the reduction, denial or termination of services or benefits; notices of the right to appeal such actions; and notices advising limited English proficient indi-

viduals of the availability of free language services, and other outreach materials.

"SEC. 3101. IMPROVING ACCESS TO SERVICES FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY.

"(a) PURPOSE.—As provided in Executive Order 13166, it is the purpose of this section—

"(1) to improve Federal agency performance regarding access to federally conducted and federally assisted programs and activities for individuals who are limited in their English proficiency;

"(2) to require each Federal agency to examine the services it provides and develop and implement a system by which limited English proficient individuals can obtain meaningful access to those services consistent with, and without substantially burdening, the fundamental mission of the agency;

"(3) to require each Federal agency to ensure that recipients of Federal financial assistance provide meaningful access to their limited English proficient applicants and beneficiaries;

"(4) to ensure that recipients of Federal financial assistance take reasonable steps, consistent with the guidelines set forth in the Limited English Proficient Guidance of the Department of Justice (as issued on June 12, 2002), to ensure meaningful ac-

cess to their programs and activities by limited English proficient individuals; and

''(5) to ensure compliance with title VI of the Civil Rights Act of 1964 and that health care providers and organizations do not discriminate in the provision of services.

''(b) FEDERALLY CONDUCTED PROGRAMS AND ACTIVITIES.—

''(1) IN GENERAL.—Not later than 120 days after the date of enactment of this title, each Federal agency that carries out health care-related activities shall prepare a plan to improve access to the federally conducted health care-related programs and activities of the agency by limited English proficient individuals. Each Federal agency must ensure that such plan is fully implemented not later than one year after the date of enactment of this Act.

''(2) PLAN REQUIREMENT.—Each plan under paragraph (1) shall include—

''(A) the steps the agency will take to ensure that limited English proficient individuals have access to the agency's federally conducted health care and health care-related programs and activities;

''(B) the policies and procedures for identifying, assessing, and meeting the language needs of its limited English proficient beneficiaries served by federally conducted programs and activities;

''(C) the steps the agency will take for its federally conducted programs and activities to provide a range of language assistance options, notice to limited English proficient individuals of the right to competent language services, periodic training of staff, monitoring and quality assessment of the language services and, in appropriate circumstances, the translation of written materials;

''(D) the steps the agency will take to ensure that applications, forms, and other relevant documents for its federally conducted programs and activities are competently translated into the primary language of a limited English proficient client where such materials are needed to improve access to federally conducted and federally assisted programs and activities for such a limited English proficient individual; and

''(E) the resources the agency will provide to assist recipients of Federal funds to improve

access to health care or health care related programs and activities for limited English proficient individuals.

Each agency shall send a copy of such plan to the Department of Justice, which shall serve as the central repository of the agencies' plans.

''(c) FEDERALLY ASSISTED PROGRAMS AND ACTIVITIES.—

''(1) IN GENERAL.—Not later than 120 days after the date of enactment of this title, each Federal agency providing health care-related Federal financial assistance shall ensure that the guidance for recipients of Federal financial assistance developed by the agency to ensure compliance with title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.) is specifically tailored to the recipients of such assistance. Each agency shall send a copy of such guidance to the Department of Justice which shall serve as the central repository of the agencies' plans. After approval by the Department of Justice, each agency shall publish its guidance document in the Federal Register for public comment.

''(2) REQUIREMENTS.—The agency-specific guidance developed under paragraph (1) shall take into account the types of health care services pro-

vided by the recipients, the individuals served by the recipients, and other factors set out in such standards.

''(3) EXISTING GUIDANCES.—A Federal agency that has developed a guidance for purposes of title VI of the Civil Rights Act of 1964 shall examine such existing guidance, as well as the programs and activities to which such guidance applies, to determine if modification of such guidance is necessary to comply with this subsection.

''(4) CONSULTATION.—Each Federal agency shall consult with the Department of Justice in establishing the guidances under this subsection.

''(d) CONSULTATIONS.—

''(1) IN GENERAL.—In carrying out this section, each Federal agency that carriers out health care and health care-related activities shall ensure that stakeholders, such as limited English proficient individuals and their representative organizations, recipients of Federal assistance, and other appropriate individuals or entities, have an adequate opportunity to provide input with respect to the actions of the agency.

''(2) EVALUATION.—Each Federal agency described in paragraph (1) shall evaluate the—

''(A) particular needs of the limited English proficient individuals served by the agency;

''(B) particular needs of the limited English proficient individuals served by the agency's recipients of Federal financial assistance; and

''(C) burdens of compliance with the agency guidance and this section for the agency and its recipients.

"SEC. 3102. NATIONAL STANDARDS FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES IN HEALTH CARE.

''Recipients of Federal financial assistance from the Secretary shall, to the extent reasonable and practicable after applying the 4-factor analysis described in title V of the Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited-English Proficient Persons (June 12, 2002)—

''(1) implement strategies to recruit, retain, and promote individuals at all levels of the organization to maintain a diverse staff and leadership that can provide culturally and linguistically appropriate

health care to patient populations of the service area of the organization;

''(2) ensure that staff at all levels and across all disciplines of the organization receive ongoing education and training in culturally and linguistically appropriate service delivery;

''(3) offer and provide language assistance services, including trained bilingual staff and interpreter services, at no cost to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation;

''(4) notify patients of their right to receive language assistance services in their primary language;

''(5) ensure the competence of language assistance provided to limited English proficient patients by interpreters and bilingual staff, and ensure that family, particularly minor children, and friends are not used to provide interpretation services—

''(A) except in case of emergency; or

''(B) except on request of the patient, who has been informed in his or her preferred language of the availability of free interpretation services;

''(6) make available easily understood patient-related materials, if such materials exist for non-lim-

ited English proficient patients, including information or notices about termination of benefits and post signage in the languages of the commonly encountered groups or groups represented in the service area of the organization;

''(7) develop and implement clear goals, policies, operational plans, and management accountability and oversight mechanisms to provide culturally and linguistically appropriate services;

''(8) conduct initial and ongoing organizational assessments of culturally and linguistically appropriate services-related activities and integrate valid linguistic competence-related measures into the internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations of the organization;

''(9) ensure that, consistent with the privacy protections provided for under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note)—

''(A) data on the individual patient's race, ethnicity, and primary language are collected in health records, integrated into the organiza-

tion's management information systems, and periodically updated; and

''(B) if the patient is a minor or is incapacitated, the primary language of the parent or legal guardian is collected;

''(10) maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area of the organization;

''(11) develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient involvement in designing and implementing culturally and linguistically appropriate services-related activities;

''(12) ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients;

''(13) regularly make available to the public information about their progress and successful innovations in implementing the standards under this

section and provide public notice in their communities about the availability of this information; and

''(14) if requested, regularly make available to the head of each Federal entity from which Federal funds are received, information about their progress and successful innovations in implementing the standards under this section as required by the head of such entity.

''SEC. 3103. ROBERT T. MATSUI CENTER FOR CULTURAL AND LINGUISTIC COMPETENCE IN HEALTH CARE.

''(a) ESTABLISHMENT.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall establish and support a center to be known as the 'Robert T. Matsui Center for Cultural and Linguistic Competence in Health Care' (referred to in this section as the 'Center') to carry out the following activities:

''(1) INTERPRETATION SERVICES.—The Center shall provide resources via the Internet to identify and link health care providers to competent interpreter and translation services.

''(2) TRANSLATION OF WRITTEN MATERIAL.—

''(A) The Center shall provide, directly or through contract, vital documents from com-

petent translation services for providers of health care and health care-related services at no cost to such providers. Materials may be submitted for translation into non-English languages. Translation services shall be provided in a timely and reasonable manner and in accordance with the guidelines and standards set forth in subsection (c) when such standards become available. The quality of such translation services shall be monitored and reported publicly.

''(B) For each form developed or revised by the Secretary that will be used by LEP individuals in health care or health care-related settings, the Center shall translate the form, at a minimum, into the top 15 non-English languages in the United States according to the most recent data from the American Community Survey or its replacement. The translation must be completed within 45 days of the Secretary receiving final approval of the form from the Office of Management and Budget.

''(3) TOLL-FREE CUSTOMER SERVICE TELEPHONE NUMBER.—The Center shall provide,

through a toll-free number, a customer service line for LEP individuals—

"(A) to obtain information about federally conducted or funded health programs, including Medicare, Medicaid, and SCHIP;

"(B) to obtain assistance with applying for or accessing these programs and understanding Federal notices written in English; and

"(C) to learn how to access language services.

"(4) HEALTH INFORMATION CLEARINGHOUSE.—

"(A) IN GENERAL.—The Center shall develop and maintain an information clearinghouse to facilitate the provision of language services by providers of health care and health care-related services to reduce medical errors, improve medical outcomes, reduce health care costs caused by miscommunication with individuals with limited English proficiency, and reduce or eliminate the duplication of effort to translate materials. The clearinghouse shall make such information available on the Internet and in print. Such information shall include the

information described in the succeeding provisions of this paragraph.

''(B) DOCUMENT TEMPLATES.—The Center shall collect and evaluate for accuracy, develop, and make available templates for standard documents that are necessary for patients and consumers to access and make educated decisions about their health care, including the following:

''(i) Administrative and legal documents, including—

''(I) intake forms;

''(II) Medicare, Medicaid, and SCHIP forms, including eligibility information;

''(III) forms informing patient of HIPAA compliance and consent; and

''(IV) documents concerning informed consent, advanced directives, and waivers of rights.

''(ii) Clinical information, such as how to take medications, how to prevent transmission of a contagious disease, and other prevention and treatment instructions.

''(iii) Public health, patient education, and outreach materials, such as immunization notices, health warnings, or screening notices.

''(iv) Additional health or health care-related materials as determined appropriate by the Director of the Center.

''(C) STRUCTURE OF FORMS.—The operating the clearinghouse, the Center shall—

''(i) ensure that the documents posted in English and non-English languages are culturally appropriate;

''(ii) allow public review of the documents before dissemination in order to ensure that the documents are understandable and culturally appropriate for the target populations;

''(iii) allow health care providers to customize the documents for their use;

''(iv) facilitate access to these documents;

''(v) provide technical assistance with respect to the access and use of such information; and

"(vi) carry out any other activities the Secretary determines to be useful to fulfill the purposes of the clearinghouse.

"(D) LANGUAGE ASSISTANCE PROGRAMS.—The Center shall provide for the collection and dissemination of information on current examples of language assistance programs and strategies to improve language services for LEP individuals, including case studies using de-identified patient information, program summaries, and program evaluations.

"(E) CULTURAL AND LINGUISTIC COMPETENCE MATERIALS.—The Center shall provide information relating to culturally and linguistically competent health care for minority populations residing in the United States to all health care providers and health care-related services at no cost. Such information shall include—

"(i) tenets of culturally and linguistically competent care;

"(ii) cultural and linguistic competence self-assessment tools;

"(iii) cultural and linguistic competence training tools;

"(iv) strategic plans to increase cultural and linguistic competence in different types of providers of health care and health care-related services, including regional collaborations among health care organizations; and

"(v) cultural and linguistic competence information for educators, practitioners, and researchers.

"(F) INFORMATION ABOUT PROGRESS.—The Center shall regularly collect and make publicly available information about the progress of entities receiving grants under section 3104 regarding successful innovations in implementing the obligations under this subsection and provide public notice in the entities' communities about the availability of this information;

"(b) DIRECTOR.—The Center shall be headed by a Director who shall be appointed by, and who shall report to, the Director of the Agency for Healthcare Research and Quality.

"(c) INTERPRETATION AND TRANSLATION GUIDELINES AND STANDARDS.—The Center shall convene a working group to develop and adopt interpretation and

translation quality guidelines and standards for use by the Center. The guidelines and standards must be sufficient to ensure that LEP individuals have the equal opportunity to benefit from health care services to the same extent as non-LEP individuals. The guidelines and standards shall address the training, assessment and certification of individuals to provide competent interpreter and translator services to work in health care and health care-related settings and of bilingual staff who provide services directly in non-English languages. The working group may develop different guidelines and standards for bilingual staff, interpreters, and translators.

''(d) MEMBERSHIP.—

''(1) QUALIFICATIONS.—The Working Group shall consist of 14 members as follows:

''(A) Four members from organizations that advocate on behalf of LEP individuals.

''(B) One member who represents a professional interpreter association (that is not the National Council on Interpreting in Health Care) or translator association.

''(C) One member from a non-profit community based organization that provides language services.

"(D) Three members recommended by the National Council on Interpreting in Health Care, including one who individual who is a professional interpreter.

"(E) Four members who are health care providers or represent health care provider associations, including one individual who represents a health care practice of fewer than 5 clinicians.

"(F) One member who works in or has extensive knowledge of issues related to health care risk management.

"(2) GEOGRAPHIC REPRESENTATION.—The membership of the Working Group shall reflect a broad geographic representation including both urban and rural representatives, including representatives of the United States territories.

"(3) PROHIBITED APPOINTMENTS.—Members of the Working Group shall not include Members of Congress or other elected Federal, State, or local government officials.

"(4) VACANCIES.—Any vacancies in the Working Group shall not affect the power and duties of the Working Group but shall be filled in the same manner as the original appointment.

''(5) SUBCOMMITTEES.—The Working Group may establish subcommittees if doing so increases the efficiency of the Working Group in completing its tasks, including subcommittees to develop different guidelines and standards for interpreters, translators, and bilingual staff.

''(6) ADVISORY PANEL TO THE WORKING GROUP.—The Working Group shall consult with the Advisory Panel in the development of the guidelines and standards. The Advisory Panel shall include—

''(A) representatives from the American Translators Association, Association of Language Companies, the National Center for State Courts, and States which have developed interpreter standards such as California, Massachusetts and Oregon who have experience in the development or implementation of their organizations' interpreter and translator certification programs;

''(B) Federal agencies including the Office for Civil Rights, the Office of Minority Health, and the Centers for Medicare & Medicaid Services and the National Center on Minority Health and Health Disparities; and

"(C) other individuals or entities determined appropriate by the Secretary who have specific expertise that will be useful to the Working Group.

"(7) PUBLICATION.—

"(A) DRAFT STANDARDS.—Not later than 18 months after the date of enactment of this title, the Working Group shall—

"(i) prepare and make available to the public through the Internet, the Federal Register, and other appropriate public channels, a proposed set of interpretation and translation guidelines and standards for training, assessment, and certification; and

"(ii) accept public comment on such guidelines and standards for a period of not less than 90 days.

"(B) FINAL STANDARDS.—Not later than 120 days after the expiration of the public comment period described in subparagraph (A), the Director of the Agency for Healthcare Research and Quality shall publish, after consultation with and the approval of the Working Group,

final guidelines and standards in the Federal Register and on the Internet.

''(C) TESTING DEVELOPMENT.—Not later than 120 days after the publication of the final recommendations described in subparagraph (B), the Director of the Agency for Healthcare Research and Quality shall, if deemed necessary by the Working Group, enter into a contract with an entity experienced in the development of designing certification tests in language related fields to develop such tests as may be necessary to implement the guidelines and standards.

''(D) PILOT PROJECT.—

''(i) Not later than 120 days after completion of the test development described in subparagraph (C) or after publication of the final guidelines and standards, whichever is later, the Secretary shall design, fund, and implement a pilot project in up to 50 geographically and demographically diverse sites, two of which must be in the U.S. territory, to test and evaluate implementation of the recommendations.

''(ii) The Secretary shall consult with the Working Group and the Advisory Panel in development of the pilot project and report progress to the Working Group on an ongoing basis.

''(iii) The pilot project shall include interpreters and translators working with various provider types, including small group practices, hospitals, and community health clinics, and shall include broad geographic representation including both urban and rural representatives.

''(iv) The pilot project shall operate for not less than two nor more than four years, as determined by the Secretary.

''(v) If the Working Group determines that any revisions to guidelines and standards are necessary as a result of the pilot project, it shall revise such guidelines and standards and the Director of the Agency for Healthcare Research and Quality shall publish the revisions in the Federal Register for notice and comment. Not later than 120 days after the expiration of the public comment period on such revisions,

the Director of the Agency for Healthcare Research and Quality shall publish, after consultation with and the approval of the Working Group, final revisions to the guidelines and standards in the Federal Register and on the Internet.

''(8) ADMINISTRATION.—

''(A) CHAIRPERSON.—Not later than 15 days after the date on which all members of the Working Group have been appointed under subsection (d), the Working Group shall designate its chairperson.

''(B) COMPENSATION.—While serving on the business of the Working Group (including travel time), a member of the Working Group or the Advisory Panel shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Working Group. For purposes of pay and employment benefits, rights, and privileges, all personnel of the

Working Group shall be treated as if they were employees of the House of Representatives.

''(C) INFORMATION FROM FEDERAL AGENCIES.—The Working Group may secure directly from any Federal department or agency such information as the Working Group considers necessary to carry out this section. Upon request of the Working Group, the head of such department or agency shall furnish such information. Any information that contains individually identifiable information received by the Working Group shall not be disseminated or disclosed outside of the Working Group and shall not be used except by the Working Group.

''(D) DETAIL.—Not more than 10 Federal Government employees employed by the Department of Health and Human Services may be detailed to staff the Working Group under this section without further reimbursement. Any detail of an employee shall be without interruption or loss of civil service status or privilege.

''(E) TEMPORARY AND INTERMITTENT SERVICES.—The Working Group may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at

rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

''(F) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for the activities of the Working Group and Advisory Panel for each of fiscal years 2010 through 2014, and for the funding of the pilot project.

''(9) DEEMED STATUS.—

''(A) CERTIFICATION BY PRIVATE ORGANIZATION.—If a private accreditation organization establishes training, assessment, or certification standards for interpreters or translators in health care which the Secretary determines are at least equivalent to the training, assessment, or certification standards promulgated by the Secretary as described in subsection (c), the Secretary shall find that all organizations or individuals accredited by such organization comply also with the standard described in subsection (c) if—

''(i) such organization or individual authorizes the organization to release to the Secretary upon the Secretary's request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such organization or individual made by the organization, together with any other information directly related to the survey as the Secretary may require (including corrective action plans); and

''(ii) such organization releases such a copy and any such information to the Secretary.

''(B) CERTIFICATION BY A STATE OR LOCALITY.—If a State or locality has or establishes training, assessment, or certification standards for interpreters or translators in health care which the Secretary determines are at least equivalent to the training, assessment, or certification standards promulgated by the Secretary as described in subsection (c), the Secretary shall find that all organizations or individuals accredited by such State or locality

comply also with the standard described in subsection (c) if—

''(i) such organization or individual authorizes the State or locality to release to the Secretary upon his request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such organization or individual made by such State or locality, together with any other information directly related to the survey as the Secretary may require (including corrective action plans); and

''(ii) such State or locality releases such a copy and any such information to the Secretary.

''(C) TIMELY ACTION ON APPLICATION.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization, State, or locality whether the process of the private accrediting organization, State, or locality meets the requirements with respect to training, assessment, or certification standards for interpreters or translators with respect to which

standards the application is made. The Secretary may not deny an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, training, assessment, or certification standards for interpreters or translators.

''(D) DISCLOSURE OF ACCREDITATION SURVEY.—The Secretary may not disclose any accreditation survey made and released to him by the National Council on Interpreting in Health Care or any State or locality of an accredited organization or individual, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.

''(E) DEFICIENCIES.—If the Secretary finds that an accredited organization or individual has significant deficiencies (as defined in regulations pertaining to the training, assessment, or certification standards), the organization or individual shall, after the date of notice of such finding to the organization and for such period as may be prescribed in regulations, be deemed not to meet the conditions or require-

ments the organization or individual has been treated as meeting pursuant to subparagraph (A).

''(e) AVAILABILITY OF LANGUAGE ACCESS.—The Director shall collaborate with the Administrator of the Office of Minority Health, the Administrator of the Centers for Medicare & Medicaid Services, and the Administrator of the Health Resources and Services Administration to notify health care providers and health care organizations about the availability of language access services by the Center.

''(f) EDUCATION.—The Secretary, directly or through contract, shall undertake a national education campaign to inform providers, LEP individuals, and health professional and graduate schools about—

''(1) Federal and State laws and guidelines governing access to language services;

''(2) the value of using trained interpreters and the risks associated with using family members, friends, minors, and untrained bilingual staff;

''(3) funding sources for developing and implementing language services; and

''(4) promising practices to effectively provide language services.

''(g) AUTHORIZATION OF APPROPRIATIONS.—In addition to the amounts authorized under subsection (e)(8)(F), there are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.

"SEC. 3104. INNOVATIONS IN CULTURAL AND LINGUISTIC COMPETENCE GRANTS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall award grants to eligible entities to enable such entities to design, implement, and evaluate innovative, cost-effective programs to improve language access in health care for individuals with limited English proficiency. The Director of the Agency for Healthcare Research and Quality shall coordinate with, and ensure the participation of, other agencies including but not limited to the Health Resources and Services Administration, the Center on Minority Health and Health Disparities at the National Institutes of Health, and the Office of Minority Health, regarding the design and evaluation of the grants program.

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a) an entity shall—

''(1) be—

"(A) a city, county, Indian tribe, State, territory or subdivision thereof;

"(B) an organization described in section 501(c)(3) of the Internal Revenue Code of 1986;

"(C) a community health center or community clinic;

"(D) a solo or group physician practice;

"(E) an integrated health care delivery system;

"(F) public hospital;

"(G) health care group, university, or college; or

"(H) other entity designated by the Secretary; and

"(2) prepare and submit to the Secretary an application, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

"(c) USE OF FUNDS.—An entity shall use funds received under a grant under this section to—

"(1) develop, implement, and evaluate models of providing competence interpretation services through on-site interpretation, telephonic interpretation, or video interpretation;

''(2) implement strategies to recruit, retain, and promote individuals at all levels of the organization to maintain a diverse staff and leadership that can promote and provide language services to patient populations of the service area of the organization;

''(3) develop and maintain a needs assessment that identifies the current demographic, cultural, and epidemiological profile of the community to accurately plan for and implement language services needed in service area of the organization;

''(4) develop a strategic plan to implement language services;

''(5) develop participatory, collaborative partnerships with communities encompassing the LEP patient populations being served to gain input in designing and implementing language services;

''(6) develop and implement grievance resolution processes that are culturally and linguistically sensitive and capable of identifying, preventing, and resolving complaints by LEP individuals; or

''(7) develop short-term medical interpretation training courses and incentives for bilingual health care staff who are asked to interpret in the workplace;

''(8) develop formal training programs for individuals interested in becoming dedicated health care interpreters and culturally competent providers;

''(9) provide staff language training instruction, which shall include information on the practical limitations of such instruction for non-native speakers; and

''(10) develop other language assistance services as determined appropriate by the Secretary; and

''(11) ensure that, consistent with the privacy protections provided for under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), and any applicable State privacy laws, data on the individual patient or recipient's race, ethnicity, and primary language are collected (and periodically updated) in health records and integrated into the organization's information management systems or any similar system used to store and retrieve data;

''(d) PRIORITY.—In awarding grants under this section, the Secretary shall give priority to entities that primarily engage in providing direct care and that have developed partnerships with community organizations or with agencies with experience language access.

''(e) EVALUATION.—

''(1) An entity that receives a grant under this section shall submit to the Secretary an evaluation that describes, in the manner and to the extent required by the Secretary, the activities carried out with funds received under the grant, and how such activities improved access to health and health care-related services and the quality of health care for individuals with limited English proficiency. Such evaluation shall be collected and disseminated through the Robert T. Matsui Center for Cultural and Linguistic Competence in Health Care established under section 3103. The Director of the Agency for Healthcare Research and Quality shall notify grantees of the availability of technical assistance for the evaluation and provide such assistance upon request.

''(2) The Director of the Agency for Healthcare Research and Quality shall evaluate or arrange with other individuals or organizations to evaluate projects funded under this section.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, $5,000,000 for each of fiscal years 2010 through 2014.

"SEC. 3105. RESEARCH ON CULTURAL AND LANGUAGE COMPETENCE.

"(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall expand research concerning language access in the provision of health care.

"(b) ELIGIBILITY.—The Director of the Agency for Healthcare Research and Quality may conduct the research described in subsection (a) or enter into contracts with other individuals or organizations to do so.

"(c) USE OF FUNDS.—Research under this section shall be designed to do one or more of the following:

"(1) To identify the barriers to mental and behavioral services that are faced by LEP individuals.

"(2) To identify health care providers' and health administrators' attitudes, knowledge, and awareness of the barriers to quality health care services that are faced by LEP individuals.

"(3) To identify optimal approaches for delivering language access.

"(4) To identify best practices for data collection, including—

"(A) the collection by providers of health care and health care-related services of data on the race, ethnicity, and primary language of recipients of such services, taking into account ex-

isting research conducted by the Government or private sector;

"(B) the development and implementation of data collection and reporting systems; and

"(C) effective privacy safeguards for collected data.

"(5) To develop a minimum data collection set for primary language.

"(6) To evaluate the most effective ways in which the Department can create or coordinate, and then subsidize or otherwise fund telephonic interpretation providers for health care providers, taking into consideration, among other factors, the flexibility necessary for such a system to accommodate variations in—

"(A) provider type;

"(B) languages needed and their frequency of use;

"(C) type of encounter;

"(D) time of encounter, including regular business hours and after hours; and

"(E) location of encounter.

"(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section,

such sums as may be necessary for each of fiscal years 2010 through 2014.''.

SEC. 102. FEDERAL REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES UNDER THE MEDICARE, MEDICAID AND THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

(a) MEDICARE.—Title XVIII of the Social Security Act is amended by adding at the end the following new section:

''MEDICARE SUPPORT FOR LANGUAGE SERVICES

''SEC. 1899.

''(a) ENSURING APPROPRIATE PAYMENT FOR THE FURNISHING OF LINGUISTICALLY APPROPRIATE LANGUAGE SERVICES TO ALL MEDICARE BENEFICIARIES.—

''(b) TEMPORARY COST-BASED PAYMENTS FOR LANGUAGE SERVICES TO HOSPITALS.—

''(1) IN GENERAL.—Not later than 90 days after enactment of this section, the Secretary shall initiate quarterly payments to all hospitals that are certified as Medicare providers (including short-term acute inpatient hospitals, long-term care hospitals, inpatient rehabilitation facilities, children's, cancer, psychiatric, and critical access hospitals) to pay for the costs of providing language services to limited English proficient Medicare beneficiaries. These pay-

ments shall cover the provision of language services by hospitals in inpatient and outpatient settings. These payments shall continue until the Secretary develops and implements reimbursement standards for language services pursuant to the process set forth in subsection (b).

''(2) DETERMINATION OF TEMPORARY PAYMENTS.—Payments under paragraph (1) shall be calculated based on the estimated numbers of LEP Medicare beneficiaries in a hospital's service area utilizing—

''(A) data on the numbers of LEP individuals (defined for purposes of this paragraph as individuals who speak English less than 'very well') from the most recently available data from the Bureau of the Census; or

''(B) the hospital's own data if—

''(i) the hospital routinely collects data on patients' primary language or need for an interpreter in both in- and out-patient settings;

''(ii) the data collection system used by the hospital is, as determined by the Secretary, likely to yield accurate data re-

garding the number of LEP individuals served by the hospital, and,

"(iii) the hospital's data documents greater numbers of LEP individuals than does the data described in clause (i).

"(C) DISTRIBUTION OF FUNDS.—On a quarterly basis, the Secretary shall pay amounts directly to eligible hospitals to pay for the costs of providing language services to LEP Medicare beneficiaries.

"(D) METHODOLOGIES.—In establishing a methodology for temporary payments, the Secretary may establish one or more payment methodologies for inpatient and outpatient settings.

"(3) REPORTING REQUIREMENTS.—Hospitals receiving payment under paragraph (1) shall provide the Secretary with two reports on—

"(A) the number of Medicare beneficiaries to whom language services are provided;

"(B) the languages of those Medicare beneficiaries;

"(C) the types of language services provided (such as provision of services directly in

non-English language by a health care provider or use of an interpreter);

"(D) type of interpretation (such as in-person, telephonic, or video interpretation);

"(E) the methods of providing language services (staff, contract with external independent contractors, or agencies);

"(F) the length of time for each interpretation encounter; and

"(G) the costs of providing language services (whether actual or estimated, as determined by the Secretary).

"(4) NO COST-SHARING.—There shall be no cost-sharing for language services provided as temporary payments to hospitals.

"(5) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this subsection such sums as may be necessary for each of fiscal years 2010 through 2014.

"(c) DEVELOPMENT OF PAYMENT AMOUNTS FOR LANGUAGE SERVICES.—

"(1) IN GENERAL.—Not later than 6 months after enactment of this section, the Secretary shall convene a Working Group to advise the Secretary on the development of payment amounts that are based

on hospital-reported costs for language services provided to LEP Medicare beneficiaries. Reimbursement shall apply to all Medicare-covered services furnished by certified providers to eligible beneficiaries, whether covered under parts A and B or under the Medicare Advantage program under part C.

''(2) VARIATIONS.—The Secretary, in consultation with the Working Group, may establish variations within the reimbursement system based upon available delivery methods and costs for providing language services including such factors as—

''(A) the type of language services provided (such as provision of services directly in a non-English language by a health care provider or use of an interpreter);

''(B) type of interpretation services provided (such as in-person, telephonic, or video interpretation);

''(C) the methods and costs of providing language services (including the costs of providing language services with internal staff or through contract with external independent contractors or agencies);

''(D) providing services for languages not frequently encountered in the United States; and

''(E) providing services in rural areas.

''(3) NO COST-SHARING.—There shall be no cost-sharing for language services provided as payments to hospitals under this subsection.

''(4) LIMITATIONS.—

''(A) IN GENERAL.—Reimbursement shall only be provided to hospitals under this subsection that report their costs of providing language services, including information on the factors described in paragraph (1) that are utilized in establishing the reimbursement rates and any other information specified by the Secretary.

''(B) USE OF INTERPRETER OR TRANSLATION SERVICES.—

''(i) IN GENERAL.—Reimbursement shall be provided under this subsection only to hospitals that utilize interpreter or translation services.

''(ii) INTERPRETER SERVICES DEFINED.—In this paragraph the term 'interpreter services' means services designed to

provide a competent trans-language rendition of a spoken message in which an interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language. Such interpreter shall know health and health-related terminology and provide accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source message.

''(iii) INTERPRETER DEFINED.—In this paragraph, the he term 'interpreter' means an individual who transmits a spoken message from one language into another, faithfully, accurately, and objectively. Such term includes an individual who provide in-person, telephonic, and video interpretation and also includes an individual who is employed or contracted by those who provide benefits under section 1832.

''(iv) TRANSLATION.—In this paragraph, the term 'translation' means the competent transmission of a written message in one language into a written message in another language.

''(v) EXEMPTIONS.—The requirements of clauses (i) and (ii) shall not apply—

''(I) when a individual (who has been informed in the individual's primary language of the availability of free interpreter and translation services) requests the use of family, friends or other persons untrained in interpretation or translation; and

''(II) when a medical emergency exists and the delay directly associated with obtaining a competent interpreter or translation services would jeopardize the health of the individual.

Nothing in this clause shall exempt emergency rooms or similar entities that regularly provide health care services in medical emergencies from having in place sys-

tems to provide competent interpreter and translation services without undue delay.

''(5) WORKING GROUP.—The Secretary shall establish a Working Group (in this subsection referred to as the 'Working Group') to develop the payment amounts under this paragraph. Such Working Group include representatives from the American Hospital Association, National Association of Public Hospitals and Health Systems, Association of Language Companies, the National Council of Interpreting in Health Care, organizations that advocate on behalf of limited English proficient individuals, and other individuals or entities determined appropriate by the Secretary, including those who have specific expertise in either developing cost-based reimbursement or provision of language services, that will be useful.

''(6) PUBLICATION.—

''(A) PROPOSED REIMBURSEMENT STANDARDS.—Not later than 18 months after the date of enactment of this section, the Secretary shall, contingent upon consultation with and approval of the Working Group—

''(i) prepare and make available to the public through the Internet, the Federal Register, and other appropriate public

channels, proposed payment amounts under this subsection based on hospital-reported costs; and

"(ii) accept public comment on such reimbursement standards for a period of not less than 90 days.

"(B) FINAL REIMBURSEMENT STANDARDS.—

"(i) IN GENERAL.—Not later than 120 days after the expiration of the public comment period described in subparagraph (A), the Secretary shall publish, after consultation with and the approval of the Working Group, final reimbursement standards in the Federal Register and on the Internet. The final reimbursement standards shall go into effect within six months of the date of such publication.

"(ii) TRAINING.—Between such publication and effective dates, the Secretary shall provide training and technical assistance to hospitals on the final reimbursement standards. As necessary, the Secretary shall continue to provide training

and technical assistance after the reimbursement standards becomes effective.

''(iii) PHASE-OUT.—When the final reimbursement standards go into effect, the temporary adjustments described in subsection (a) shall be phased out over a one-year period as hospitals implement the new reimbursement rates. Final reimbursement rates shall not be constrained at the level of total temporary adjustments. Reimbursement shall be set at the level of the costs of language services at eligible hospitals.

''(d) OTHER MEDICARE PAYMENT SYSTEMS.—

''(1) PAYMENT SYSTEMS.—

''(A) IN GENERAL.—Not later than two years after enactment of this Act, and using the guidelines described in subsection (b), the Secretary shall make recommendations to include payments or adjustments for language services provided to limited English proficient Medicare beneficiaries for all of the remaining payment systems under this title, except the physician fee schedule under such 1848, including psychiatric hospitals, skilled nursing facilities,

home health agencies, rehabilitation facilities, and long-term care hospitals, as well as the TEFRA per discharge limit for children's and cancer hospitals excluded from the inpatient hospital prospective payment system under section 1886(d), the ambulance fee schedule, and payments to critical access hospitals. Program costs for language services in critical access hospitals shall be considered allowable costs under this title and shall be calculated in the same manner as other Medicare costs on the cost report. These costs should be incorporated into interim payments.

''(B) IMPLEMENTATION.—The Secretary shall implement these payments within three years.

''(C) NO COST-SHARING.—There shall be no cost-sharing for such language services.

''(2) MEDICARE REIMBURSEMENT FOR LANGUAGE SERVICES PROVIDED IN SUPPORT OF PHYSICIAN OFFICE SERVICES.—

''(A) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that examines ways that Medicare can pay for language services (including foreign language and

sign language) provided in support of physician office services and other services paid for through the physician fee schedule under section 1848. The report on such study shall include the following:

"(i) Recommendations and effective methods for adopting a payment methodology for on-site interpreters, pursuant to which such interpreters and agencies could directly bill Medicare for language services provided in support of benefits paid for under section 1832 for a limited English proficient Medicare patient. For purposes of this subparagraph, the term 'on-site interpreters' include interpreters who work as independent contractors, for agencies that provide on-site interpretation, and who are employed by those who provide benefits provided under section 1832.

"(ii) Recommendations and effective methods for Medicare contracting directly with agencies that provide off-site interpretation, including telephonic and video interpretation, pursuant to which such contractors could directly bill Medicare for the

services provided in support of benefits provided under section 1832 for a limited English proficient Medicare patient.

"(iii) Recommendations for modifying the existing Medicare resource-based relative value scale (RBRVS) by adding new procedure codes in the Health Care Common Procedure Coding System.

"(B) REPORT.—Not later than 1 year after the date of the enactment of this section, the Commission shall submit to Congress and the Centers for Medicare & Medicaid Services a report on the study conducted under subparagraph (A), together with recommendations regarding the appropriateness of directly reimbursing interpreters versus physicians for language services provided in support of benefits provided under section 1832.

"(C) IMPLEMENTATION.—

"(i) IN GENERAL.—Not later than 1 year after the submission of the report designated in subparagraph (B), the Secretary shall publish, after consultation with and the approval of the Medicare Payment Advisory Commission, final reimbursement

standards for language services provided in support of benefits provided under section 1832. These standards shall be published in the Federal Register and on the Internet and shall go into effect within six months of the date of such publication. The final standards must ensure that—

"(I) for the first three years of implementation, the payments for language services do not diminish other fees provided in support of benefits provided under section 1832; and

"(II) enrollees do not have to pay any co-pays or cost-sharing for language services provided in support of benefits provided under section 1832.

"(ii) TRAINING.—Between such date of publication and the effective date, the Secretary shall provide training and technical assistance to providers covered by the physician fee schedule under section 1848 on the final reimbursement standards. As necessary, the Secretary shall continue to provide training and technical assistance

after the reimbursement standards becomes effective.''.

(b) CONFORMING AMENDMENTS.—

(1) TECHNICAL AMENDMENTS.—

(A) Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Language Services; Interpreter Services; Interpreter; Translation; LEP

''(hhh)(1) The term 'language services' means the provision of healthcare services to limited English proficient enrollees directly in a non-English language, or through the provision of interpreter services, translation and non-English signage.

''(2) For the purposes of this subsection, the term 'interpreter services' means services designed to provide a competent trans-language rendition of a spoken message in which an interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language and interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest

possible extent, all nuances intended in the source message.

''(3) The term 'interpreter' means an individual who transmits a spoken message from one language into another, faithfully, accurately, and objectively. Such term includes individuals who provide in-person, telephonic, and video interpretation and such term 'interpreter' individuals who are employed or contracted by those who provide benefits provided under section 1832.

''(4) The term 'translation' means the competent transmission of a written message in one language into a written message in another language.

''(5) The terms 'limited English proficient' and 'LEP', with respect to an individual, means an individual who speaks a primary language other than English.''.

(B) Subsection (aa)(1)(B) of such section is amended by inserting '', language services as defined in subsection (hhh),'' after ''clinical social worker (as defined in subsection (hh)(1)),''.

(C) Section 1833(a) of the Social Security Act (42 U.S.C. 1395l) is amended—

(i) by redesignating paragraph (9) as paragraph (10); and

(ii) by inserting after paragraph (8) the following new paragraph:

''(9) in the case of language services described in section 1861(hhh), 100 percent of the reasonable charges for such services.''.

(D) Section 1832(a)(2) of such Act (42 U.S.C. 1395k(a)(2)) is amended—

(i) by striking ''and'' at the end of subparagraph (I);

(ii) by striking the period at the end of subparagraph (K) and inserting ''and''; and

(iii) by adding at the end of subparagraph (K) the following:

''(L) language services (as defined in section 1861(hhh) furnished by a interpreter or translator, whether contracted or employed by the entity providing benefits under this section.''

(E) WAIVER OF BUDGET NEUTRALITY.—For the first 3 years after the effective date of this section, the budget neutrality provision of section 1848(c)(2)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)) shall not apply to language services.

(F) EFFECTIVE DATE.—These amendments made by this subsection are effective

upon publication of the final reimbursement standards described in section 1899(b) of the Social Security Act, as added by subsection (a).

(2) MEDICARE PART C AND PART D.—The Secretary of Health and Human Services shall ensure Medicare Advantage plans participating in Medicare part C and prescription drug plans participating in Medicare part D effectively provide language services to their enrollees. The Secretary shall require annual reporting for such plans that includes information on internal policies and procedures related to cultural appropriateness in each of the following contexts:

(A) Collection of data regarding the enrollee population.

(B) Education of plan staff and contractors who have routine contact with enrollees regarding the diverse needs of the enrollee population.

(C) Recruitment and retention efforts that encourage workforce diversity.

(D) Evaluation of the health plan's language services programs and services with respect to the plan's enrollee population, using

processes such as an analysis of complaints and satisfaction survey results.

(E) Methods by which the plan provides information regarding the ethnic diversity of the plan's enrollee population.

(F) The periodic provision of educational information to plan enrollee on the plan's language services and programs. Plans may use existing means of communications.

(c) IMPROVING LANGUAGE SERVICES IN MEDICAID AND SCHIP.—

(1) Section 1903(a)(2)(E) of the Social Security Act (42 U.S.C. 1396b(a)(2)(E)) is amended by—

(A) striking ''translation or interpretation services'' and inserting ''language services''; and

(B) striking ''children of families'' and inserting ''individuals''.

(2) Section 1902(a)(10)(A) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)) is amended by striking ''and (21)'' and inserting ''(21), and (28)''.

(3) Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended by—

(A) in paragraph (27), by striking ''and'' at the end;

(B) by redesignating paragraph (28) as paragraph (29); and

(C) by inserting after paragraph (27) the following new paragraph:

''(27) language services (including the provision of health care services directly in a non-English language, interpretation, translation, and non-English signage), provided in a timely manner to limited English proficient individuals who need language services in connection with administrative and covered services; and''.

(4) Section 1916(a)(2) of the Social Security Act (42 U.S.C. 1396o(2)) is amended by—

(A) by striking ''or'' at the end of subparagraph (D);

(B) by striking ''and'' at the end of subparagraph (E) and inserting ''or''; and

(C) by adding at the end the following new subparagraph:

''(F) language services described in section 1905(a)(27); and''.

(5) Section 2103 of the Social Security Act (42 U.S.C. 1397cc) is amended—

(A) in subsection (a), in the matter before paragraph (1), by striking ''(7)'' and inserting '', (7), and (9)''; and

(B) in subsection (c), by adding at the end the following new paragraph:

''(9) LANGUAGE SERVICES.—The child health assistance provided to a targeted low-income child shall include coverage of language services (including the provision of health care services directly in a non-English language, interpretation, translation and non-English signage) provided in a timely manner to limited English proficient individuals who need them, in connection with administrative and covered services.''; and

(C) in subsection (e)(2)—

(i) in the heading, by striking ''PREVENTIVE'' and inserting ''CERTAIN''; and

(ii) by inserting ''or subsection (c)(9)'' after ''subsection (c)(1)(C)''.

(6) Section 2110(a)(27) of the Social Security Act (42 U.S.C. 1397jj) is amended by striking ''translation'' and inserting ''language services as described in section 2103(c)(7)''.

(7) Pursuant to the reporting requirement described in section 2107(b)(1) of the Social Security

Act (42 U.S.C. 1397gg(b)(1)), the Secretary of Health and Human Services shall ensure that States collect data on the—

(A) primary language of those assisted; and

(B) for individuals who are minors or incapacitated, the primary language of the individual's parent or guardian.

(8) Section 2105(c)(2)(A) of the Social Security Act (42 U.S.C. 1397ee(c)) is amended by inserting before the period ", except that expenditures pursuant to section 2105(a)(1)(D)(iv) shall not count towards this total".

(d) FUNDING LANGUAGE SERVICES FURNISHED BY PROVIDERS OF HEALTH CARE AND HEALTH CARE-RELATED SERVICES THAT SERVE HIGH RATES OF UNINSURED LEP INDIVIDUALS.—

(1) PAYMENT OF COSTS.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary of Health and Human Services shall make payments (on a quarterly basis) directly to eligible entities to support the provision of language services to limited English proficient individuals in an amount equal to an

entity's eligible costs for such services for the quarter.

(B) LIMITATION.—If the amount of funds appropriated under subparagraph (C) to carry out this subsection for a fiscal year is insufficient to ensure that each eligible entity can receive full payment under subparagraph (A), the Secretary shall reduce in a pro rata manner the amount of such payment to each such entity.

(C) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary of Health and Human Services such sums as may be necessary for each of fiscal years 2010 through 2014.

(D) LANGUAGE SERVICES.—In this subsection, the term ''language services'' has the meaning given such term in section 3100 of the Public Health Service Act.

(2) ELIGIBLE COSTS DEFINED.—

(A) IN GENERAL.—In this subsection, the term ''eligible costs'' means, with respect to an eligible entity that provides language services to LEP individuals, the product of—

(i) the average per person cost of language services, determined according to the methodology devised under subparagraph (B), and

(ii) the number of limited English proficient individuals who are provided language services by the entity and for whom no reimbursement is available for such services under the amendments made by subsections (a), (b), or (c) or by private health insurance.

(B) METHODOLOGY.—The Secretary shall devise a methodology to determine the average per person cost of language services. In establishing a payment methodology, the Secretary may establish different methodologies for different types of eligible entities. The Secretary shall not require eligible entities to provide individual claims for language services for each individual patient to be provided payment under this subsection.

(3) ELIGIBLE ENTITY.—In order to receive grants under this paragraph, an entity must—

(A) be—

(i) an individual provider;

(ii) a hospital with a low income utilization rate (as defined in section 1923(b)(3) of the Social Security Act (42 U.S.C. 1396r–4(b)(3))) of greater than 25 percent; or

(iii) a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)));

(B) provide language services to at least 8 percent of the entity's total number of patients; and

(C) prepare and submit an application to the Secretary, at such time, in such manner, and accompanied by such information as the Secretary may require to ascertain the entities' eligibility for funding under this subsection.

(4) RELATION TO MEDICAID DSH.—Payments under this subsection shall not offset or reduce payments under section 1923 of the Social Security Act, nor shall payments under such section be considered when determining uncompensated costs associated with the provision of language services.

(5) REPORTING REQUIREMENTS.—Entities receiving payment under this subsection shall provide

the Secretary with a quarterly report on such payments. Such report shall contain aggregate (and not individualized) data and shall otherwise be in a form and manner determined by the Secretary. For purposes of this subsection, the Secretary shall create a standard data collection instrument that is consistent with any existing reporting requirements by the Secretary or relevant accrediting organizations regarding the number of individuals to whom language access are provided.

(6) GUIDANCE.—

(A) ESTABLISHMENT.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall establish guidelines concerning the implementation of this subsection.

(B) REPORT.—Not later than 2 years after the date of enactment of this Act, and every 2 years thereafter, the Secretary shall submit a report to Congress concerning the implementation of such guidelines.

(e) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2009.

SEC. 103. INCREASING UNDERSTANDING OF AND IMPROVING HEALTH LITERACY.

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and the Administrator of the Health Resources and Services Administration, in consultation with the National Center on Minority Health and Health Disparities and the Office of Minority Health, shall award grants to eligible entities to improve health care for patient populations that have low functional health literacy.

(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

(1) be a hospital, health center or clinic, health plan, or other health entity (including a nonprofit minority health organization or association); and

(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(c) USE OF FUNDS.—

(1) AGENCY FOR HEALTHCARE RESEARCH AND QUALITY.—Grants awarded under subsection (a) through the Agency for Healthcare Research and Quality shall be used—

(A) to define and increase the understanding of health literacy;

(B) to investigate the correlation between low health literacy and health and health care;

(C) to clarify which aspects of health literacy have an effect on health outcomes; and

(D) for any other activity determined appropriate by the Director of the Agency.

(2) HEALTH RESOURCES AND SERVICES ADMINISTRATION.—Grants awarded under subsection (a) through the Health Resources and Services Administration shall be used to conduct demonstration projects for interventions for patients with low health literacy that may include—

(A) the development of new disease management programs for patients with low health literacy;

(B) the tailoring of existing disease management programs addressing mental, physical, oral, and behavioral health conditions for patients with low health literacy;

(C) the translation of written health materials for patients with low health literacy;

(D) the identification, implementation, and testing of low health literacy screening tools;

(E) the conduct of educational campaigns for patients and providers about low health literacy; and

(F) other activities determined appropriate by the Administrator of the Health Resources and Services Administration.

(d) DEFINITIONS.—In this section, the term ''low health literacy'' means the inability of an individual to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2014.

SEC. 104. ASSURANCES FOR RECEIVING FEDERAL FUNDS.

(a) IN GENERAL.—Entities that receive Federal funds under sections 101 or 102 (including under the amendments made by such section), in order to ensure the right of LEP individuals to receive access to quality health care, shall—

(1) ensure that appropriate clinical and support staff receive ongoing education and training in linguistically appropriate service delivery;

(2) offer and provide appropriate language services at no additional charge to each patient with lim-

ited English proficiency at all points of contact, in a timely manner during all hours of operation;

(3) notify patients of their right to receive language services in their primary language; and

(4) utilize only competent interpreter or translation services which—

(A) until adoption of the Interpreter and Translator Guidelines and Standards described in section 3103(c) of the Public Health Service Act, are defined in section 3100 of the Public Health Service Act; and

(B) after adoption of the Interpreter and Translator Guidelines and Standards described in section 3103(c) of the Public Health Service Act, meet those guidelines and standards;

(b) EXEMPTIONS.—The requirements of subsection (a)(4) shall not apply as follows:

(1) When a patient (who has been informed in his or her primary language of the availability of free interpreter and translation services) requests the use of family, friends or other persons untrained in interpretation or translation if the following conditions are met:

(A) The interpreter requested by the patient is over the age of 18.

(B) The recipient informs the patient that he or she has the option of having the recipient provide an interpreter for him/her without charge, or of using his/her own interpreter.

(C) The recipient informs the patient that the recipient may not require an LEP person to use a family member or friend as an interpreter.

(D) The recipient evaluates whether the person the patient wishes to use as an interpreter is competent. If the recipient has reason to believe that the interpreter is not competent, the recipient provides its own interpreter to protect the recipient from liability if the patient's interpreter is later found not competent.

(E) If the recipient has reason to believe that there is a conflict of interest between the interpreter and patient, the recipient may not use the patient's interpreter.

(F) The recipient has the patient sign a waiver, witnessed by at least one individual not related to the patient, that includes the information stated in subparagraphs (A) through (E) and is translated into the patient's language.

(2) When a medical emergency exists and the delay directly associated with obtaining competent interpreter or translation services would jeopardize the health of the patient but only until a competent interpreter or translation service is available; however, nothing in this subsection shall exempt emergency rooms or similar entities that regularly provide health care services in medical emergencies from having in place systems to provide competent interpreter and translation services without undue delay.

SEC. 105. REPORT ON FEDERAL EFFORTS TO PROVIDE CULTURALLY AND LINGUISTICALLY APPROPRIATE HEALTH CARE SERVICES.

(a) REPORT.—Not later than 1 year after the date of enactment of this Act and annually thereafter, the Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine for the preparation and publication of a report that describes Federal efforts to ensure that all individuals with limited English proficiency have meaningful access to health care and health care-related services. Such report shall include—

(1) a description and evaluation of the activities carried out under this Act;

(2) a description and analysis of best practices, model programs, guidelines, and other effective strategies for providing access to culturally and linguistically appropriate health care services;

(3) recommendations on the development and implementation of policies and practices by providers of health care and health care-related services for limited English proficient individuals;

(4) a description of the effect of providing language services on quality of health care and access to care; and

(5) a description of the costs associated with or savings related to the provision of language services.

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2014.

SEC. 106. ENGLISH FOR SPEAKERS OF OTHER LANGUAGES.

(a) GRANTS AUTHORIZED.—The Secretary of Education is authorized to provide grants to States for the provision of English as a second language (hereafter referred to as ''ESL'') instruction and shall determine, after consultation with appropriate stakeholders, the mechanism for administering and distributing such grants.

(b) APPLICATION.—A State may apply for a grant under this section by submitting such information as the Secretary may require and in such form and manner as the Secretary may require.

(c) USE OF GRANT.—As a condition of receiving a grant under this section, a State shall—

(1) develop and implement a plan for assuring the availability of ESL instruction that effectively integrates information about the nature of the United States health care system, how to access care, and any special language skills that may be required for them to access and regularly negotiate the system effectively;

(2) develop a plan, including, where appropriate, public-private partnerships, for making ESL instruction progressively available to all individuals seeking instruction; and

(3) maintain current ESL instruction efforts by using the additional funds to supplement rather than supplant any funds expended for ESL instruction in the State as of January 1, 2006.

(d) ADDITIONAL DUTIES OF THE SECRETARY.—The Secretary of Education shall—

(1) collect and publicize annual data on how much Federal, State, and local governments spend on ESL instruction;

(2) collect data from state and local governments to identify the unmet needs of English language learners for appropriate ESL instruction, including—

(A) the extent of waiting lists including how many programs maintain waiting lists and, for programs that do not have waiting lists, the reasons why not;

(B) the availability of programs to geographically isolated communities;

(C) the impact of course enrollment policies, including open enrollment, on the availability of ESL instruction;

(D) the number individuals in the State and each participating locality;

(E) the effectiveness of the instruction in meeting the needs of individuals receiving instruction and those needing instruction;

(F) as assessment of the need for programs that integrate job training and ESL instruction, to assist individuals to obtain better jobs; and

(G) the availability of ESL slots by State and locality;

(3) determine the cost and most appropriate methods of making ESL instruction available to all English language learners seeking instruction; and

(4) within 1 year of the date of enactment of this Act, issue a report to Congress that assesses the information collected in subparagraphs (1), (2), and (3) and makes recommendations on steps that should be taken to progressively realize the goal of making ESL instruction available to all English language learners seeking instruction.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary of Education for each of fiscal years 2010 through 2013 $250,000,000 to carry out this section.

SEC. 107. DEFINITION.

In this title, the definitions contained in section 3100 of the Public Health Service Act, as added by section 101, shall apply.

SEC. 108. TREATMENT OF THE MEDICARE PART B PROGRAM UNDER TITLE VI OF THE CIVIL RIGHTS ACT OF 1964.

A payment to a provider of services, physician, or other supplier under part B, C, ord D of title XVIII of

the Social Security Act shall be deemed a grant, and not a contract of insurance or guaranty, for the purposes of title VI of the Civil Rights Act of 1964.

SEC. 109. IMPLEMENTATION.

(a) GENERAL PROVISIONS.—

(1) A State shall not be immune under the Eleventh Amendment of the Constitution of the United States from suit in Federal court for failing to provide the language access funded pursuant to this Act.

(2) In a suit against a State for a violation of this Act, remedies (including remedies at both at law and in equity) are available for such a violation to the same extent as such remedies are available for such a violation in the suit against any public or private entity other than a State.

(b) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed to limit otherwise existing obligations of recipients of Federal financial assistance under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et seq.) or any other statute.

TITLE II—HEALTH WORKFORCE DIVERSITY

SEC. 201. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title XXXI of the Public Health Service Act, as added by section 201, is amended by adding at the end the following:

"Subtitle A—Diversifying the Healthcare Workplace

"SEC. 3111. REPORT ON WORKFORCE DIVERSITY.

''(a) IN GENERAL.—Not later than July 1, 2010, and biannually thereafter, the Secretary, acting through the director of each entity within the Department of Health and Human Services, shall prepare and submit to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives a report on health workforce diversity.

''(b) REQUIREMENT.—The report under subsection (a) shall contain the following information:

''(1) A description of any grant support that is provided by each entity for workforce diversity initiatives with the following information—

''(A) the number of grants made;

''(B) the purpose of the grants;

''(C) the populations served through the grants;

''(D) the organizations and institutions receiving the grants; and

''(E) the tracking efforts that were used to follow the progress of participants.

''(2) A description of the entity's plan to achieve workforce diversity goals that includes, to the extent relevant to such entity—

''(A) the number of underrepresented minority health professionals that will be needed in various disciplines over the next 10 years to achieve population parity;

''(B) the level of funding needed to fully expand and adequately support health professions pipeline programs;

''(C) the impact such programs have had on the admissions practices and policies of health professions schools;

''(D) the management strategy necessary to effectively administer and institutionalize health profession pipeline programs; and

''(E) the impact that the Government Performance and Results Act (GPRA) has had on evaluating the performance of grantees and

whether the GPRA is the best assessment tool for programs under titles VII and VIII.

''(3) A description of measurable objectives of each entity relating to workforce diversity initiatives.

''(c) PUBLIC AVAILABILITY.—The report under subsection (a) shall be made available for public review and comment.

''SEC. 3112. NATIONAL WORKING GROUP ON WORKFORCE DIVERSITY.

''(a) IN GENERAL.—The Secretary, acting through the Bureau of Health Professions within the Health Resources and Services Administration, shall award a grant to an entity determined appropriate by the Secretary for the establishment of a national working group on workforce diversity.

''(b) REPRESENTATION.—In establishing the national working group under subsection (a), the grantee shall ensure that the group has representation from the following entities:

''(1) The Health Resources and Services Administration.

''(2) The Department of Health and Human Services Data Council.

''(3) The Office of Minority Health.

''(4) The Bureau of Labor Statistics of the Department of Labor.

''(5) The Public Health Practice Program Office—Office of Workforce Policy and Planning.

''(6) The National Center on Minority Health and Health Disparities.

''(7) The Agency for Healthcare Research and Quality.

''(8) The Institute of Medicine Study Committee for the 2004 workforce diversity report.

''(9) The Indian Health Service.

''(10) Academic institutions.

''(11) Consumer organizations.

''(12) Health professional associations, including those that represent underrepresented minority populations.

''(13) Researchers in the area of health workforce.

''(14) Health workforce accreditation entities.

''(15) Private foundations that have sponsored workforce diversity initiatives.

''(16) Not less than 5 health professions students representing various health profession fields and levels of training.

''(c) ACTIVITIES.—The working group established under subsection (a) shall convene at least twice each year to complete the following activities:

''(1) Review current public and private health workforce diversity initiatives.

''(2) Identify successful health workforce diversity programs and practices.

''(3) Examine challenges relating to the development and implementation of health workforce diversity initiatives.

''(4) Draft a national strategic work plan for health workforce diversity, including recommendations for public and private sector initiatives.

''(5) Develop a framework and methods for the evaluation of current and future health workforce diversity initiatives.

''(6) Develop recommended standards for workforce diversity that could be applicable to all health professions programs and programs funded under this Act.

''(7) Develop curriculum guidelines for diversity training.

''(8) Develop a strategy for the inclusion of community members on admissions committees for health profession schools.

''(9) Other activities determined appropriate by the Secretary.

''(d) ANNUAL REPORT.—Not later than 1 year after the establishment of the working group under subsection (a), and annually thereafter, the working group shall prepare and make available to the general public for comment, an annual report on the activities of the working group. Such report shall include the recommendations of the working group for improving health workforce diversity.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

''SEC. 3113. TECHNICAL CLEARINGHOUSE FOR HEALTH WORKFORCE DIVERSITY.

''(a) IN GENERAL.—The Secretary, acting through the Office of Minority Health, and in collaboration with the Bureau of Health Professions within the Health Resources and Services Administration, the National Center on Minority Health and Health Disparities, shall establish a technical clearinghouse on health workforce diversity within the Office of Minority Health and coordinate current and future clearinghouses.

''(b) INFORMATION AND SERVICES.—The clearinghouse established under subsection (a) shall offer the following information and services:

''(1) Information on the importance of health workforce diversity.

''(2) Statistical information relating to underrepresented minority representation in health and allied health professions and occupations.

''(3) Model health workforce diversity practices and programs.

''(4) Admissions policies that promote health workforce diversity and are in compliance with Federal and State laws.

''(5) Lists of scholarship, loan repayment, and loan cancellation grants as well as fellowship information for underserved populations for health professions schools.

''(6) Foundation and other large organizational initiatives relating to health workforce diversity.

''(c) CONSULTATION.—In carrying out this section, the Secretary shall consult with non-Federal entities which may include minority health professional associations to ensure the adequacy and accuracy of information.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section,

such sums as may be necessary for each of fiscal years 2010 through 2015.

"SEC. 3114. EVALUATION OF WORKFORCE DIVERSITY INITIATIVES.

"(a) IN GENERAL.—The Secretary, acting through the Bureau of Health Professions within the Health Resources and Services Administration, shall award grants to eligible entities for the conduct of an evaluation of current health workforce diversity initiatives funded by the Department of Health and Human Services.

"(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a) an entity shall—

"(1) be a city, county, Indian tribe, State, territory, community-based nonprofit organization, health center, university, college, or other entity determined appropriate by the Secretary;

"(2) with respect to an entity that is not an academic medical center, university, or private research institution, carry out activities under the grant in partnership with an academic medical center, university, or private research institution; and

"(3) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—Amounts awarded under a grant under subsection (a) shall be used to support the following evaluation activities:

''(1) Determinations of measures of health workforce diversity success.

''(2) The short- and long-term tracking of participants in health workforce diversity pipeline programs funded by the Department of Health and Human Services.

''(3) Assessments of partnerships formed through activities to increase health workforce diversity.

''(4) Assessments of barriers to health workforce diversity.

''(5) Assessments of policy changes at the Federal, State, and local levels.

''(6) Assessments of coordination within and between Federal agencies and other institutions.

''(7) Other activities determined appropriate by the Secretary and the Working Group established under section 3112.

''(d) REPORT.—Not later than 1 year after the date of enactment of this title, the Bureau of Health Professions within the Health Resources and Services Administration shall prepare and make available for public com-

ment a report that summarizes the findings made by entities under grants under this section.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

''SEC. 3115. DATA COLLECTION AND REPORTING BY HEALTH PROFESSIONAL SCHOOLS.

''(a) IN GENERAL.—The Secretary, acting through the Bureau of Health Professions of the Health Resources and Services Administration and the Office of Minority Health, shall establish an aggregated database on health professional students.

''(b) REQUIREMENT TO COLLECT DATA.—Each health professional school (including medical, dental, and nursing schools) and allied health profession school and program that receives Federal funds shall collect race, ethnicity, and language proficiency data concerning those students enrolled at such schools or in such programs. In collecting such data, a school or program shall—

''(1) at a minimum, use the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity and available language standards; and

''(2) if practicable, collect data on additional population groups if such data can be aggregated into the minimum race and ethnicity data categories.

''(c) USE OF DATA.—Data on race, ethnicity, primary language, gender, and sexual orientation collected under this section shall be reported to the database established under subsection (a) on an annual basis. Such data shall be available for public use.

''(d) PRIVACY.—The Secretary shall ensure that all data collected under this section is protected from inappropriate internal and external use by any entity that collects, stores, or receives the data and that such data is collected without personally identifiable information.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

''SEC. 3116. SUPPORT FOR INSTITUTIONS COMMITTED TO WORKFORCE DIVERSITY.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants to eligible entities that demonstrate a commitment to health workforce diversity.

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

''(1) be an educational institution or entity that historically produces or trains meaningful numbers of underrepresented minority health professionals, including—

''(A) Historically Black Colleges and Universities;

''(B) Hispanic-Serving Health Professions Schools;

''(C) Hispanic-Serving Institutions;

''(D) Tribal Colleges and Universities;

''(E) Asian American and Pacific Islander-serving institutions;

''(F) institutions that have programs to recruit and retain underrepresented minority health professionals, in which a significant number of the enrolled participants are underrepresented minorities;

''(G) health professional associations, which may include underrepresented minority health professional associations; and

''(H) institutions—

''(i) located in communities with predominantly underrepresented minority populations;

''(ii) with whom partnerships have been formed for the purpose of increasing workforce diversity; and

''(iii) in which at least 20 percent of the enrolled participants are underrepresented minorities; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—Amounts received under a grant under subsection (a) shall be used to expand existing workforce diversity programs, implement new workforce diversity programs, or evaluate existing or new workforce diversity programs, including with respect to mental health care professions. Such programs shall enhance diversity by considering minority status as part of an individualized consideration of qualifications. Possible activities may include—

''(1) educational outreach programs relating to opportunities in the health professions;

''(2) scholarship, fellowship, grant, loan repayment, and loan cancellation programs;

''(3) post-baccalaureate programs;

''(4) academic enrichment programs, particularly targeting those who would not be competitive for health professions schools;

''(5) kindergarten through 12th grade and other health pipeline programs;

''(6) mentoring programs;

''(7) internship or rotation programs involving hospitals, health systems, health plans and other health entities;

''(8) community partnership development for purposes relating to workforce diversity; or

''(9) leadership training.

''(d) REPORTS.—Not later than 1 year after receiving a grant under this section, and annually for the term of the grant, a grantee shall submit to the Secretary a report that summarizes and evaluates all activities conducted under the grant.

''(e) DEFINITION.—In this section, the term 'Asian American and Pacific Islander-serving institutions' means institutions—

''(1) that are eligible institutions under section 312(b) of the Higher Education Act of 1965; and

''(2) that, at the time of their application, have an enrollment of undergraduate students that is

made up of at least 10 percent Asian American and Pacific Islander students.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

''SEC. 3117. CAREER DEVELOPMENT FOR SCIENTISTS AND RESEARCHERS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Commissioner of Food and Drugs, and the Director of the Agency for Healthcare Research and Quality, shall award grants that expand existing opportunities for scientists and researchers and promote the inclusion of underrepresented minorities in the health professions.

''(b) RESEARCH FUNDING.—The head of each entity within the Department of Health and Human Services shall establish or expand existing programs to provide research funding to scientists and researchers in-training. Under such programs, the head of each such entity shall give priority in allocating research funding to support health research in traditionally underserved communities, including underrepresented minority communities, and research classified as community or participatory.

''(c) DATA COLLECTION.—The head of each entity within the Department of Health and Human Services shall collect data on the number (expressed as an absolute number and a percentage) of underrepresented minority and nonminority applicants who receive and are denied agency funding at every stage of review. Such data shall be reported annually to the Secretary and the appropriate committees of Congress.

''(d) STUDENT LOAN REIMBURSEMENT.—The Secretary shall establish a student loan reimbursement program to provide student loan reimbursement assistance to researchers who focus on racial and ethnic disparities in health. The Secretary shall promulgate regulations to define the scope and procedures for the program under this subsection.

''(e) STUDENT LOAN CANCELLATION.—The Secretary shall establish a student loan cancellation program to provide student loan cancellation assistance to researchers who focus on racial and ethnic disparities in health. Students participating in the program shall make a minimum 5-year commitment to work at an accredited health profession school. The Secretary shall promulgate additional regulations to define the scope and procedures for the program under this subsection.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

"SEC. 3118. CAREER SUPPORT FOR NON-RESEARCH HEALTH PROFESSIONALS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, the Administrator of the Substance Abuse and Mental Health Services Administration, the Administrator of the Health Resources and Services Administration, and the Administrator of the Centers for Medicare and Medicaid Services shall establish a program to award grants to eligible individuals for career support in non-research-related healthcare.

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a) an individual shall—

''(1) be a student in a health professions school, a graduate of such a school who is working in a health profession, or a faculty member of such a school; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—An individual shall use amounts received under a grant under this section to—

''(1) support the individual's health activities or projects that involve underserved communities, including racial and ethnic minority communities;

''(2) support health-related career advancement activities; and

''(3) to pay, or as reimbursement for payments of, student loans for individuals who are health professionals and are focused on health issues affecting underserved communities, including racial and ethnic minority communities.

''(d) DEFINITION.—In this section, the term 'career in non-research-related healthcare' means employment or intended employment in the field of public health, health policy, health management, health administration, medicine, nursing, pharmacy, allied health, community health, or other fields determined appropriate by the Secretary, other than in a position that involves research.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

"SEC. 3119. RESEARCH ON THE EFFECT OF WORKFORCE DIVERSITY ON QUALITY.

''(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, in collaboration with the Director of the Office of Minority Health and the Director of the National Center on Minority Health and Health Disparities, shall award grants to eligible entities to expand research on the link between health workforce diversity and quality healthcare.

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a) an entity shall—

''(1) be a clinical, public health, or health services research entity or other entity determined appropriate by the Director; and

''(2) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—Amounts received under a grant awarded under subsection (a) shall be used to support research that investigates the effect of health workforce diversity on—

''(1) language access;

''(2) cultural competence;

''(3) patient satisfaction;

''(4) timeliness of care;

''(5) safety of care;

''(6) effectiveness of care;

''(7) efficiency of care;

''(8) patient outcomes;

''(9) community engagement;

''(10) resource allocation;

''(11) organizational structure;

''(12) other topics determined appropriate by the Director; or

''(13) compliance of care.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director shall give individualized consideration to all relevant aspects of the applicant's background. Consideration of prior research experience involving the health of underserved communities shall be such a factor.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

"SEC. 3120. HEALTH DISPARITIES EDUCATION PROGRAM.

''(a) ESTABLISHMENT.—The Secretary, acting through the National Center on Minority Health and Health Disparities and in collaboration with the Office of Minority Health, the Office for Civil Rights, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Health Resources and

Services Administration, and other appropriate public and private entities, shall establish and coordinate a health and healthcare disparities education program to support, develop, and implement educational initiatives and outreach strategies that inform healthcare professionals and the public about the existence of and methods to reduce racial and ethnic disparities in health and healthcare.

''(b) ACTIVITIES.—The Secretary, through the education program established under subsection (a) shall, through the use of public awareness and outreach campaigns targeting the general public and the medical community at large—

''(1) disseminate scientific evidence for the existence and extent of racial and ethnic disparities in healthcare, including disparities that are not otherwise attributable to known factors such as access to care, patient preferences, or appropriateness of intervention, as described in the 2002 Institute of Medicine Report, Unequal Treatment;

''(2) disseminate new research findings to healthcare providers and patients to assist them in understanding, reducing, and eliminating health and healthcare disparities;

''(3) disseminate information about the impact of linguistic and cultural barriers on healthcare qual-

ity and the obligation of health providers who receive Federal financial assistance to ensure that people with limited English proficiency have access to language access services;

''(4) disseminate information about the importance and legality of racial, ethnic, and primary language data collection, analysis, and reporting;

''(5) design and implement specific educational initiatives to health care providers relating to health and health care disparities; and

''(6) assess the impact of the programs established under this section in raising awareness of health and healthcare disparities and providing information on available resources.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

''SEC. 3120A. CULTURAL COMPETENCE TRAINING FOR HEALTHCARE PROFESSIONALS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, the Director of the Office of Minority Health, and the Director of the National Center for Minority Health and Health Disparities, shall award grants

to eligible entities to test, implement, and evaluate models of cultural competence training, including continuing education, for healthcare providers in coordination with the initiative under section 3120(a).

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

''(1) be an academic medical center, a health center or clinic, a hospital, a health plan, a health system, or a health care professional guild (including a mental health care professional guild);

''(2) partner with a minority serving institution, minority professional association, or community-based organization representing minority populations, in addition to a research institution to carry out activities under this grant; and

''(3) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.''.

SEC. 202. HEALTH CAREERS OPPORTUNITY PROGRAM.

(a) PURPOSE.—It is the purpose of this section to diversify the healthcare workforce by increasing the number of individuals from disadvantaged backgrounds in the health and allied health professions by enhancing the academic skills of students from disadvantaged backgrounds and supporting them in successfully competing, entering, and graduating from health professions training programs.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 740(c) of the Public Health Service Act (42 U.S.C. 293d(c)) is amended by striking ''$29,400,000'' and all that follows through ''2002'' and inserting ''$50,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015''.

SEC. 203. PROGRAM OF EXCELLENCE IN HEALTH PROFESSIONS EDUCATION FOR UNDERREPRESENTED MINORITIES.

(a) PURPOSE.—It is the purpose of this section to diversify the healthcare workforce by supporting programs of excellence in designated health professions schools that demonstrate a commitment to underrepresented minority populations with a focus on minority health issues, cultural and linguistic competence, and eliminating health disparities.

(b) AUTHORIZATION OF APPROPRIATION.—Section 736(h)(1) of the Public Health Service Act (42 U.S.C. 293(h)(1)) is amended to read as follows:

''(1) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of making grants under subsection (a), there are authorized to be appropriated $50,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2015.''.

SEC. 204. HISPANIC-SERVING HEALTH PROFESSIONS SCHOOLS.

Part B of title VII of the Public Health Service Act (42 U.S.C. 293 et seq.) is amended by adding at the end the following:

''SEC. 742. HISPANIC-SERVING HEALTH PROFESSIONS SCHOOLS.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall award grants to Hispanic-serving health professions schools for the purpose of carrying out programs to recruit Hispanic individuals to enroll in and graduate from such schools, which may include providing scholarships and other financial assistance as appropriate.

''(b) ELIGIBILITY.—In subsection (a), the term 'Hispanic-serving health professions school' means an entity that—

''(1) is a school or program under section 799B;

''(2) has an enrollment of full-time equivalent students that is made up of at least 9 percent Hispanic students;

''(3) has been effective in carrying out programs to recruit Hispanic individuals to enroll in and graduate from the school;

''(4) has been effective in recruiting and retaining Hispanic faculty members; and

''(5) has a significant number of graduates who are providing health services to medically underserved populations or to individuals in health professional shortage areas.''.

SEC. 205. HEALTH PROFESSIONS STUDENT LOAN FUND; AUTHORIZATIONS OF APPROPRIATIONS REGARDING STUDENTS FROM DISADVANTAGED BACKGROUNDS.

Section 724(f)(1) of the Public Health Service Act (42 U.S.C. 292t(f)(1)) is amended by striking ''$8,000,000'' and all that follows and inserting ''$35,000,000 for fiscal year 2010, and such sums as may

be necessary for each of the fiscal years 2011 through 2015.''.

SEC. 206. NATIONAL HEALTH SERVICE CORPS; RECRUITMENT AND FELLOWSHIPS FOR INDIVIDUALS FROM DISADVANTAGED BACKGROUNDS.

(a) IN GENERAL.—Section 331(b) of the Public Health Service Act (42 U.S.C. 254d(b)) is amended by adding at the end the following:

''(3) The Secretary shall ensure that the individuals with respect to whom activities under paragraphs (1) and (2) are carried out include individuals from disadvantaged backgrounds, including activities carried out to provide health professions students with information on the Scholarship and Repayment Programs.''.

(b) ASSIGNMENT OF CORPS PERSONNEL.—Section 333(a) of the Public Health Service Act (42 U.S.C. 254f(a)) is amended by adding at the end the following:

''(4) In assigning Corps personnel under this section, the Secretary shall give preference to applicants who request assignment to a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act) or to a provider organization that has a majority of patients who are minorities or individuals from low-income families (families with a family income that is less than 200 percent of the Official Poverty Line).''.

SEC. 207. LOAN REPAYMENT PROGRAM OF CENTERS FOR DISEASE CONTROL AND PREVENTION.

Section 317F(c) of the Public Health Service Act (42 U.S.C. 247b–7(c)) is amended—

(1) by striking ''and'' after ''1994,''; and

(2) by inserting before the period the following: ''$750,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2015.''.

SEC. 208. COOPERATIVE AGREEMENTS FOR ONLINE DEGREE PROGRAMS AT SCHOOLS OF PUBLIC HEALTH AND SCHOOLS OF ALLIED HEALTH.

Part B of title VII of the Public Health Service Act (42 U.S.C. 293 et seq.), as amended by section 204, is further amended by adding at the end the following:

''SEC. 743. COOPERATIVE AGREEMENTS FOR ONLINE DEGREE PROGRAMS.

''(a) COOPERATIVE AGREEMENTS.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, in consultation with the Director of the Centers for Disease Control and Prevention, the Director of the Agency for Healthcare Research and Quality, and the Director of the Office of Minority Health, shall award cooperative agreements to schools of public health and schools of allied health to design and implement online degree programs.

''(b) PRIORITY.—In awarding cooperative agreements under this section, the Secretary shall give priority to any school of public health or school of allied health that has an established track record of serving medically underserved communities.

''(c) REQUIREMENTS.—Awardees must design and implement an online degree program, that meet the following restrictions:

''(1) Enrollment of individuals who have obtained a secondary school diploma or its recognized equivalent.

''(2) Maintaining a significant enrollment of underrepresented minority or disadvantaged students.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.''.

SEC. 209. MID-CAREER HEALTH PROFESSIONS SCHOLARSHIP PROGRAM.

Part B of title VII of the Public Health Service Act (as amended by section 208) is further amended by adding at the end the following:

"SEC. 744. MID-CAREER HEALTH PROFESSIONS SCHOLARSHIP PROGRAM.

''(a) IN GENERAL.—The Secretary may make grants to eligible schools for awarding scholarships to eligible individuals to attend the school involved, for the purpose of enabling the individuals to make a career change from a non-health profession to a health profession.

''(b) EXPENSES.—Amounts awarded as a scholarship under this section—

''(1) subject to paragraph (2), may be expended only for tuition expenses, other reasonable educational expenses, and reasonable living expenses incurred in the attendance of the school involved; and

''(2) may be expended for stipends to eligible individuals for the enrolled period at eligible schools, except that such a stipend may not be provided to an individual for more than 4 years, and such a stipend may not exceed $35,000 per year (notwithstanding any other provision of law regarding the amount of stipends).

''(c) DEFINITIONS.—In this section:

''(1) ELIGIBLE SCHOOL.—The term 'eligible school' means a school of medicine, osteopathic medicine, dentistry, nursing (as defined in section 801), pharmacy, podiatric medicine, optometry, veterinary medicine, public health, chiropractic, or allied health,

a school offering a graduate program in mental and behavioral health practice, or an entity providing programs for the training of physician assistants and nurse midwives.

''(2) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual who has obtained a secondary school diploma or its recognized equivalent.

''(d) PRIORITY.—In providing scholarships to eligible individuals, eligible schools shall give to individuals from disadvantaged backgrounds.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.''.

SEC. 210. NATIONAL REPORT ON THE PREPAREDNESS OF HEALTH PROFESSIONALS TO CARE FOR DIVERSE POPULATIONS.

The Secretary of Health and Human Services, in collaboration with the Bureau of Health Professions, the Office of Minority Health and the National Center on Minority Health and Health Disparities, shall prepare and disseminate a report that details and assesses the preparedness of health professionals to care for racially and ethnically diverse populations. Such information, which shall

be collected by the Bureau of Health Professions, shall include—

(1) with respect to health professions education, the number and percentage of hours of classroom discussion relating to minority health issues, including cultural competence;

(2) a description of the coursework involved in such education;

(3) a description of the results of an evaluation of the preparedness of students in such education;

(4) a description of the types of exposure that students have during their education to minority patient populations; and

(5) a description of model programs and practices.

SEC. 211. SCHOLARSHIP AND FELLOWSHIP PROGRAMS.

Subtitle A of title XXXI of the Public Health Service Act, as amended by section 201, is further amended by adding at the end the following:

"SEC. 3120B. DAVID SATCHER PUBLIC HEALTH AND HEALTH SERVICES CORPS.

''(a) IN GENERAL.—The Administrator of the Health Resources and Services Administration and Director of the Centers for Disease Control and Prevention, in collaboration with the Director of the Office of Minority

Health, shall award grants to eligible entities to increase awareness among post-primary and post-secondary students of career opportunities in the health professions.

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a) an entity shall—

''(1) be a clinical, public health or health services organization, community-based or non-profit entity, or other entity determined appropriate by the Director of the Centers for Disease Control and Prevention;

''(2) serve a health professional shortage area, as determined by the Secretary;

''(3) work with students, including those from racial and ethnic minority backgrounds, that have expressed an interest in the health professions; and

''(4) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—Grant awards under subsection (a) shall be used to support internships that will increase awareness among students of non-research based and career opportunities in the following health professions:

''(1) Medicine.

''(2) Nursing.

''(3) Public Health.

''(4) Pharmacy.

''(5) Health Administration and Management.

''(6) Health Policy.

''(7) Psychology.

''(8) Dentistry.

''(9) International Health.

''(10) Social Work.

''(11) Allied Health.

''(12) Psychiatry.

''(13) Hospice care.

''(14) Other professions deemed appropriate by the Director of the Centers for Disease Control and Prevention.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director of the Centers for Disease Control and Prevention shall give priority to those entities that—

''(1) serve a high proportion of individuals from disadvantaged backgrounds;

''(2) have experience in health disparity elimination programs;

''(3) facilitate the entry of disadvantaged individuals into institutions of higher education; and

''(4) provide counseling or other services designed to assist disadvantaged individuals in successfully completing their education at the post-secondary level.

''(e) STIPENDS.—The Secretary may approve stipends under this section for individuals for any period of education in student-enhancement programs (other than regular courses) at health professions schools, programs, or entities, except that such a stipend may not be provided to an individual for more than 6 months, and such a stipend may not exceed $20 per day (notwithstanding any other provision of law regarding the amount of stipends).

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

''SEC. 3120C. LOUIS STOKES PUBLIC HEALTH SCHOLARS PROGRAM.

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Director of the Office of Minority Health, shall award scholarships to postsecondary students who seek a career in public health.

''(b) ELIGIBILITY.—To be eligible to receive a scholarship under subsection (a) an individual shall—

''(1) have experience in public health research or public health practice, or other health professions as determined appropriate by the Director of the Centers for Disease Control and Prevention;

''(2) reside in a health professional shortage area as determined by the Secretary;

''(3) have expressed an interest in public health;

''(4) demonstrate promise for becoming a leader in public health;

''(5) secure admission to a 4-year institution of higher education;

''(6) comply with subsection (f); and

''(7) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—Amounts received under an award under subsection (a) shall be used to support opportunities for students to become public health professionals.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director shall give priority to those students that—

''(1) are from disadvantaged backgrounds;

''(2) have secured admissions to a minority serving institution; and

''(3) have identified a health professional as a mentor at their school or institution and an academic advisor to assist in the completion of their baccalaureate degree.

''(e) SCHOLARSHIPS.—The Secretary may approve payment of scholarships under this section for such individuals for any period of education in student undergraduate tenure, except that such a scholarship may not be provided to an individual for more than 4 years, and such scholarships may not exceed $10,000 per academic year (notwithstanding any other provision of law regarding the amount of scholarship).

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

''SEC. 3120D. PATSY MINK HEALTH AND GENDER RESEARCH FELLOWSHIP PROGRAM.

''(a) IN GENERAL.—The Director of the Centers for Disease Control and Prevention, in collaboration with the Director of the Office of Minority Health, the Administrator of the Substance Abuse and Mental Health Services Administration, and the Director of the Indian Health Services, shall award research fellowships to post-baccalaureate students to conduct research that will examine

gender and health disparities and to pursue a career in the health professions.

''(b) ELIGIBILITY.—To be eligible to receive a fellowship under subsection (a) an individual shall—

''(1) have experience in health research or public health practice;

''(2) reside in a health professional shortage area as determined by the Secretary;

''(3) have expressed an interest in the health professions;

''(4) demonstrate promise for becoming a leader in the field of women's health;

''(5) secure admission to a health professions school or graduate program with an emphasis in gender studies;

''(6) comply with subsection (f); and

''(7) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—Amounts received under an award under subsection (a) shall be used to support opportunities for students to become researchers and advance the research base on the intersection between gender and health.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director of the Centers for Disease Control and Prevention shall give priority to those applicants that—

''(1) are from disadvantaged backgrounds; and

''(2) have identified a mentor and academic advisor who will assist in the completion of their graduate or professional degree and have secured a research assistant position with a researcher working in the area of gender and health.

''(e) FELLOWSHIPS.—The Director of the Centers for Disease Control and Prevention may approve fellowships for individuals under this section for any period of education in the student's graduate or health profession tenure, except that such a fellowship may not be provided to an individual for more than 3 years, and such a fellowship may not exceed $18,000 per academic year (notwithstanding any other provision of law regarding the amount of fellowship).

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

"SEC. 3120E. PAUL DAVID WELLSTONE INTERNATIONAL HEALTH FELLOWSHIP PROGRAM.

''(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, in collaboration with the Director of the Office of Minority Health, shall award research fellowships to college students or recent graduates to advance their understanding of international health.

''(b) ELIGIBILITY.—To be eligible to receive a fellowship under subsection (a) an individual shall—

''(1) have educational experience in the field of international health;

''(2) reside in a health professional shortage area as determined by the Secretary;

''(3) demonstrate promise for becoming a leader in the field of international health;

''(4) be a college senior or recent graduate of a four year higher education institution;

''(5) comply with subsection (f); and

''(6) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—Amounts received under an award under subsection (a) shall be used to support opportunities for students to become health professionals and

to advance their knowledge about international issues relating to healthcare access and quality.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director shall give priority to those applicants that—

''(1) are from a disadvantaged background; and

''(2) have identified a mentor at a health professions school or institution, an academic advisor to assist in the completion of their graduate or professional degree, and an advisor from an international health Non-Governmental Organization, Private Volunteer Organization, or other international institution or program that focuses on increasing healthcare access and quality for residents in developing countries.

''(e) FELLOWSHIPS.—The Secretary shall approve fellowships for college seniors or recent graduates, except that such a fellowship may not be provided to an individual for more than 6 months, may not be awarded to a graduate that has not been enrolled in school for more than 1 year, and may not exceed $4,000 per academic year (notwithstanding any other provision of law regarding the amount of fellowship).

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section,

such sums as may be necessary for each of fiscal years 2010 through 2015.

"SEC. 3120F. EDWARD R. ROYBAL HEALTHCARE SCHOLAR PROGRAM.

"(a) IN GENERAL.—The Director of the Agency for Healthcare Research and Quality, the Director of the Centers for Medicaid and Medicare, and the Administrator for Health Resources and Services Administration, in collaboration with the Director of the Office of Minority Health, shall award grants to eligible entities to expose entering graduate students to the health professions.

"(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a) an entity shall—

"(1) be a clinical, public health or health services organization, community-based or non-profit entity, or other entity determined appropriate by the Director of the Agency for Healthcare Research and Quality;

"(2) serve in a health professional shortage area as determined by the Secretary;

"(3) work with students obtaining a degree in the health professions; and

"(4) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) USE OF FUNDS.—Amounts received under a grant awarded under subsection (a) shall be used to support opportunities that expose students to non-research based health professions, including—

''(1) public health policy;

''(2) healthcare and pharmaceutical policy;

''(3) healthcare administration and management;

''(4) health economics; and

''(5) other professions determined appropriate by the Director of the Agency for Healthcare Research and Quality.

''(d) PRIORITY.—In awarding grants under subsection (a), the Director of the Agency for Healthcare Research and Quality shall give priority to those entities that—

''(1) have experience with health disparity elimination programs;

''(2) facilitate training in the fields described in subsection (c); and

''(3) provide counseling or other services designed to assist such individuals in successfully completing their education at the post-secondary level.

''(e) STIPENDS.—The Secretary may approve the payment of stipends for individuals under this section for

any period of education in student-enhancement programs (other than regular courses) at health professions schools or entities, except that such a stipend may not be provided to an individual for more than 2 months, and such a stipend may not exceed $100 per day (notwithstanding any other provision of law regarding the amount of stipends).

''(f) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section such sums as may be necessary for each of fiscal years 2010 through 2015.''.

SEC. 212. ADVISORY COMMITTEE ON HEALTH PROFESSIONS TRAINING FOR DIVERSITY.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary'') shall establish an advisory committee to be known as the Advisory Committee on Health Professions Training for Diversity (in this section referred to as the ''Advisory Committee'').

(b) COMPOSITION.—

(1) IN GENERAL.—The Secretary shall determine the appropriate number of individuals to serve on the Advisory Committee. Such individuals shall not be officers or employees of the Federal Government.

(2) APPOINTMENT.—Not later than 60 days after the date of enactment of this section, the Secretary shall appoint the members of the Advisory Committee from among individuals who are health professionals. In making such appointments, the Secretary shall ensure a fair balance between the health professions, that at least 75 percent of the members of the Advisory Committee are health professionals, a broad geographic representation of members and a balance between urban and rural members. Members shall be appointed based on their competence, interest, and knowledge of the mission of the profession involved.

(3) MINORITY REPRESENTATION.—In appointing the members of the Advisory Committee under paragraph (2), the Secretary shall ensure the adequate representation of women and minorities.

(c) TERMS.—

(1) IN GENERAL.—A member of the Advisory Committee shall be appointed for a term of 3 years, except that of the members first appointed—

(A) ⅓ of such members shall serve for a term of 1 year;

(B) ⅓ of such members shall serve for a term of 2 years; and

(C) ⅓ of such members shall serve for a term of 3 years.

(2) VACANCIES.—

(A) IN GENERAL.—A vacancy on the Advisory Committee shall be filled in the manner in which the original appointment was made and shall be subject to any conditions which applied with respect to the original appointment.

(B) FILLING UNEXPIRED TERM.—An individual chosen to fill a vacancy shall be appointed for the unexpired term of the member replaced.

(d) DUTIES.—

(1) IN GENERAL.—The Advisory Committee shall—

(A) provide advice and recommendations to the Secretary concerning policy and program development and other matters of significance concerning activities under this part; and

(B) not later than 2 years after the date of enactment of this section, and annually thereafter, prepare and submit to the Secretary, and the Committee on Health, Education, Labor and Pensions of the Senate, and the Committee on Energy and Commerce of the

House of Representatives, a report describing the activities of the Committee.

(2) CONSULTATION WITH STUDENTS.—In carrying out duties under paragraph (1), the Advisory Committee shall consult with individuals who are attending health professions schools with which this part is concerned.

(e) MEETINGS AND DOCUMENTS.—

(1) MEETINGS.—The Advisory Committee shall meet not less than 2 times each year. Such meetings shall be held jointly with other related entities established under this title where appropriate.

(2) DOCUMENTS.—Not later than 14 days prior to the convening of a meeting under paragraph (1), the Advisory Committee shall prepare and make available an agenda of the matters to be considered by the Advisory Committee at such meeting. At any such meeting, the Advisory Committee shall distribute materials with respect to the issues to be addressed at the meeting. Not later than 30 days after the adjourning of such a meeting, the Advisory Committee shall prepare and make available a summary of the meeting and any actions taken by the Committee based upon the meeting.

(f) COMPENSATION AND EXPENSES.—

(1) COMPENSATION.—Each member of the Advisory Committee shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Committee.

(2) EXPENSES.—The members of the Advisory Committee shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Committee.

(g) FACA.—The Federal Advisory Committee Act shall apply to the Advisory Committee under this section only to the extent that the provisions of such Act do not conflict with the requirements of this section.

SEC. 213. MCNAIR POSTBACCALAUREATE ACHIEVEMENT PROGRAM.

Section 402E of the Higher Education Act of 1965 (20 U.S.C. 1070a–15) is amended by striking subsection (g) and inserting the following:

''(g) COLLABORATION IN HEALTH PROFESSION DIVERSITY TRAINING PROGRAMS.—The Secretary of Education shall coordinate with the Secretary of Health and Human Services to ensure that there is collaboration between the goals of the program under this section and programs of the Health Resources and Services Administration that promote health workforce diversity. The Secretary of Education shall take such measures as may be necessary to encourage participants in programs under this section to consider health profession careers.

''(h) FUNDING.—From amounts appropriated pursuant to the authority of section 402A(g), the Secretary shall, to the extent practicable, allocate funds for projects authorized by this section in an amount which is not less than $31,000,000 for each of the fiscal years 2010 through 2016.''.

TITLE III—DATA COLLECTION AND REPORTING

SEC. 301. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

(a) PURPOSE.—It is the purpose of this section to promote data collection, analysis, and reporting by race, ethnicity, and primary language among federally supported health programs.

(b) AMENDMENT.—Title XXXI of the Public Health Service Act, as amended by title II of this Act, is further amended by adding at the end the following:

"Subtitle B—Strengthening Data Collection, Improving Data Analysis, and Expanding Data Reporting

"SEC. 3131. DATA ON RACE, ETHNICITY, AND PRIMARY LANGUAGE.

''(a) REQUIREMENTS.—

''(1) IN GENERAL.—Each health-related program operated by or that receives funding or reimbursement, in whole or in part, either directly or indirectly from the Department of Health and Human Services shall—

''(A) require the collection, by the agency or program involved, of data on the race, ethnicity, primary language, and sexual orientation of each applicant for and recipient of health-related assistance under such program—

''(i) using, at a minimum, the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting,

and Presenting Federal Data on Race and Ethnicity;

"(ii) using the standards developed under subsection (e) for the collection of language data;

"(iii) collecting data for additional population groups if such groups can be aggregated into the minimum race and ethnicity categories; and

"(iv) where practicable, through self-report;

"(B) with respect to the collection of the data described in subparagraph (A) for applicants and recipients who are minors or otherwise legally incapacitated, require that—

"(i) such data be collected from the parent or legal guardian of such an applicant or recipient; and

"(ii) the preferred language of the parent or legal guardian of such an applicant or recipient be collected;

"(C) systematically analyze such data using the smallest appropriate units of analysis feasible to detect racial and ethnic disparities as well as disparities along lines of sexual orienta-

tion in health and health care and when appropriate, for men and women separately, and report the results of such analysis to the Secretary, the Director of the Office for Civil Rights, the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives;

''(D) provide such data to the Secretary on at least an annual basis; and

''(E) ensure that the provision of assistance to an applicant or recipient of assistance is not denied or otherwise adversely affected because of the failure of the applicant or recipient to provide race, ethnicity, primary language, gender, and sexual orientation data.

''(2) RULES OF CONSTRUCTION.—Nothing in this subsection shall be construed to—

''(A) permit the use of information collected under this subsection in a manner that would adversely affect any individual providing any such information; and

"(B) require health care providers to collect data.

"(b) PROTECTION OF DATA.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) is protected—

"(1) under the same privacy protections as the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) relating to the privacy of individually identifiable health information and other protections; and

"(2) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

"(c) NATIONAL PLAN OF THE DATA COUNCIL.—The Secretary shall develop and implement a national plan to ensure the collection of data in a culturally appropriate and competent manner, and to improve the collection, analysis, and reporting of racial, ethnic, and primary language data at the Federal, State, territorial, Tribal, and

local levels, including data to be collected under subsection (a). The Data Council of the Department of Health and Human Services, in consultation with the National Committee on Vital Health Statistics, the Office of Minority Health, and other appropriate public and private entities, shall make recommendations to the Secretary concerning the development, implementation, and revision of the national plan. Such plan shall include recommendations on how to—

''(1) implement subsection (a) while minimizing the cost and administrative burdens of data collection and reporting;

''(2) expand awareness among Federal agencies, States, territories, Indian tribes, health providers, health plans, health insurance issuers, and the general public that data collection, analysis, and reporting by race, ethnicity, and primary language is legal and necessary to assure equity and non-discrimination in the quality of health care services;

''(3) ensure that future patient record systems have data code sets for racial, ethnic, primary language, and sexual orientation identifiers and that such identifiers can be retrieved from clinical records, including records transmitted electronically;

''(4) improve health and health care data collection and analysis for more population groups if such groups can be aggregated into the minimum race and ethnicity categories, including exploring the feasibility of enhancing collection efforts in States for racial and ethnic groups that comprise a significant proportion of the population of the State;

''(5) provide researchers with greater access to racial, ethnic, and primary language data, subject to privacy and confidentiality regulations; and

''(6) safeguard and prevent the misuse of data collected under subsection (a).

''(d) COMPLIANCE WITH STANDARDS.—Data collected under subsection (a) shall be obtained, maintained, and presented (including for reporting purposes) in accordance with the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity (at a minimum).

''(e) LANGUAGE COLLECTION STANDARDS.—Not later than 1 year after the date of enactment of this title, the Deputy Assistant Secretary for Minority Health, in consultation with the Office for Civil Rights of the Department of Health and Human Services, shall develop and disseminate Standards for the Classification of Federal Data on Preferred Written and Spoken Language.

''(f) TECHNICAL ASSISTANCE FOR THE COLLECTION AND REPORTING OF DATA.—

''(1) IN GENERAL.—The Secretary may, either directly or through grant or contract, provide technical assistance to enable a health care program or an entity operating under such program to comply with the requirements of this section.

''(2) TYPES OF ASSISTANCE.—Assistance provided under this subsection may include assistance to—

''(A) enhance or upgrade computer technology that will facilitate racial, ethnic, and primary language data collection and analysis;

''(B) improve methods for health data collection and analysis including additional population groups beyond the Office of Management and Budget categories if such groups can be aggregated into the minimum race and ethnicity categories;

''(C) develop mechanisms for submitting collected data subject to existing privacy and confidentiality regulations; and

''(D) develop educational programs to inform health insurance issuers, health plans, health providers, health-related agencies, and

the general public that data collection and reporting by race, ethnicity, and preferred language are legal and essential for eliminating health and health care disparities.

''(g) ANALYSIS OF RACIAL AND ETHNIC DATA.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality and in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall provide technical assistance to agencies of the Department of Health and Human Services in meeting Federal standards for race, ethnicity, and primary language data collection and analysis of racial and ethnic disparities in health and health care in public programs by—

''(1) identifying appropriate quality assurance mechanisms to monitor for health disparities;

''(2) specifying the clinical, diagnostic, or therapeutic measures which should be monitored;

''(3) developing new quality measures relating to racial and ethnic disparities in health and health care;

''(4) identifying the level at which data analysis should be conducted; and

''(5) sharing data with external organizations for research and quality improvement purposes.

''(h) REPORT.—Not later than 2 years after the date of enactment of this title, and biennially thereafter, the Secretary shall submit to the appropriate committees of Congress a report on the effectiveness of data collection, analysis, and reporting on race, ethnicity, and primary language under the programs and activities of the Department of Health and Human Services and under other Federal data collection systems with which the Department interacts to collect relevant data on race and ethnicity. The report shall evaluate the progress made in the Department with respect to the national plan under subsection (c) or subsequent revisions thereto.

''(i) DEFINITION.—In this section, the term 'health-related program' mean a program—

''(1) under the Social Security Act (42 U.S.C. 301 et seq.) that pay for health care and services; and

''(2) under this Act that provide Federal financial assistance for health care, biomedical research, health services research, and programs designed to improve the public's health.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

"SEC. 3132. PROVISIONS RELATING TO NATIVE AMERICANS.

"(a) ESTABLISHMENT OF EPIDEMIOLOGY CENTERS.—The Secretary shall establish an epidemiology center in each service area to carry out the functions described in subsection (b). Any new center established after the date of the enactment of the Health Equity and Accountability Act of 2009 may be operated under a grant authorized by subsection (d), but funding under such a grant shall not be divisible.

"(b) FUNCTIONS OF CENTERS.—In consultation with and upon the request of Indian Tribes, Tribal Organizations, and Urban Indian Organizations, each service area epidemiology center established under this subsection shall, with respect to such service area—

"(1) collect data relating to, and monitor progress made toward meeting, each of the health status objectives of the Service, the Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the service area;

"(2) evaluate existing delivery systems, data systems, and other systems that impact the improvement of Indian health;

"(3) assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations in identifying their highest priority health status objectives and the

services needed to achieve such objectives, based on epidemiological data;

''(4) make recommendations for the targeting of services needed by the populations served;

''(5) make recommendations to improve health care delivery systems for Indians and Urban Indians;

''(6) provide requested technical assistance to Indian Tribes, Tribal Organizations, and Urban Indian Organizations in the development of local health service priorities and incidence and prevalence rates of disease and other illness in the community; and

''(7) provide disease surveillance and assist Indian Tribes, Tribal Organizations, and Urban Indian Organizations to promote public health.

''(c) TECHNICAL ASSISTANCE.—The Director of the Centers for Disease Control and Prevention shall provide technical assistance to the centers in carrying out the requirements of this subsection.

''(d) GRANTS FOR STUDIES.—

''(1) IN GENERAL.—The Secretary may make grants to Indian Tribes, Tribal Organizations, Urban Indian Organizations, and eligible intertribal

consortia to conduct epidemiological studies of Indian communities.

''(2) ELIGIBLE INTERTRIBAL CONSORTIA.—An intertribal consortium is eligible to receive a grant under this subsection if—

''(A) the intertribal consortium is incorporated for the primary purpose of improving Indian health; and

''(B) the intertribal consortium is representative of the Indian Tribes or urban Indian communities in which the intertribal consortium is located.

''(3) APPLICATIONS.—An application for a grant under this subsection shall be submitted in such manner and at such time as the Secretary shall prescribe.

''(4) REQUIREMENTS.—An applicant for a grant under this subsection shall—

''(A) demonstrate the technical, administrative, and financial expertise necessary to carry out the functions described in paragraph (5);

''(B) consult and cooperate with providers of related health and social services in order to avoid duplication of existing services; and

"(C) demonstrate cooperation from Indian tribes or Urban Indian Organizations in the area to be served.

"(5) USE OF FUNDS.—A grant awarded under paragraph (1) may be used—

"(A) to carry out the functions described in subsection (b);

"(B) to provide information to and consult with tribal leaders, urban Indian community leaders, and related health staff on health care and health service management issues; and

"(C) in collaboration with Indian Tribes, Tribal Organizations, and urban Indian communities, to provide the Service with information regarding ways to improve the health status of Indians.

"(e) ACCESS TO INFORMATION.—An epidemiology center operated by a grantee pursuant to a grant awarded under subsection (d) shall be treated as a public health authority for purposes of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033), as such entities are defined in part 164.501 of title 45, Code of Federal Regulations (or a successor regulation). The Secretary shall grant such grantees access to and use of data, data sets, monitoring systems,

delivery systems, and other protected health information in the possession of the Secretary.''.

SEC. 302. COLLECTION OF RACE AND ETHNICITY DATA BY THE SOCIAL SECURITY ADMINISTRATION.

Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following:

''SEC. 1150A. COLLECTION OF RACE AND ETHNICITY DATA BY THE SOCIAL SECURITY ADMINISTRATION.

''(a) REQUIREMENT.—The Commissioner of Social Security, in consultation with the Administrator of the Centers for Medicare & Medicaid Services, shall—

''(1) require the collection of data on the race, ethnicity, and primary language of all applicants for social security account numbers or benefits under title II or part A of title XVIII and all individuals with respect to whom the Commissioner maintains records of wages and self-employment income in accordance with reports received by the Commissioner or the Secretary of the Treasury—

''(A) using, at a minimum, the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal

Data on Race and Ethnicity and available language standards; and

"(B) where practicable, collecting data for additional population groups if such groups can be aggregated into the minimum race and ethnicity categories;

"(2) with respect to the collection of the data described in paragraph (1) for applicants who are under 18 years of age or otherwise legally incapacitated, require that—

"(A) such data be collected from the parent or legal guardian of such an applicant; and

"(B) the primary language of the parent or legal guardian of such an applicant or recipient be used;

"(3) require that such data be uniformly analyzed and reported at least annually to the Commissioner of Social Security;

"(4) be responsible for storing the data reported under paragraph (3);

"(5) ensure transmission to the Centers for Medicare & Medicaid Services and other Federal health agencies;

"(6) provide such data to the Secretary on at least an annual basis; and

''(7) ensure that the provision of assistance to an applicant is not denied or otherwise adversely affected because of the failure of the applicant to provide race, ethnicity, and primary language data.

''(b) PROTECTION OF DATA.—The Commissioner of Social Security shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant subsection (a) is protected—

''(1) under the same privacy protections as the Secretary applies to health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) relating to the privacy of individually identifiable health information and other protections; and

''(2) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

''(c) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to permit the use of information collected under this section in a manner that would ad-

versely affect any individual providing any such information.

''(d) TECHNICAL ASSISTANCE.—The Secretary may, either directly or by grant or contract, provide technical assistance to enable any health entity to comply with the requirements of this section.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.''.

SEC. 303. REVISION OF HIPAA CLAIMS STANDARDS.

(a) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary of Health and Human Services shall revise the regulations promulgated under part C of title XI of the Social Security Act (42 U.S.C. 1320d et seq.), as added by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191), relating to the collection of data on race, ethnicity, and primary language in a health-related transaction to require—

(1) the use, at a minimum, of the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity;

(2) the establishment of a new data code set for primary language; and

(3) the designation of the racial, ethnic, and primary language code sets as ''required'' for claims and enrollment data.

(b) DISSEMINATION.—The Secretary of Health and Human Services shall disseminate the new standards developed under subsection (a) to all health entities that are subject to the regulations described in such subsection and provide technical assistance with respect to the collection of the data involved.

(c) COMPLIANCE.—The Secretary of Health and Human Services shall require that health entities comply with the new standards developed under subsection (a) not later than 2 years after the final promulgation of such standards.

SEC. 304. NATIONAL CENTER FOR HEALTH STATISTICS.

Section 306(n) of the Public Health Service Act (42 U.S.C. 242k(n)) is amended—

(1) in paragraph (1), by striking ''2003'' and inserting ''2014'';

(2) in paragraph (2), in the first sentence, by striking ''2003'' and inserting ''2014''; and

(3) in paragraph (3), by striking ''2002'' and inserting ''2014''.

SEC. 305. GEO-ACCESS STUDY.

The Administrator of the Substance Abuse and Mental Health Services Administration shall—

(1) conduct a study to—

(A) determine which geographic areas of the United States have shortages of specialty mental health providers; and

(B) assess the preparedness of speciality mental health providers to deliver culturally and linguistically appropriate services; and

(2) submit a report to the Congress on the results of such study.

SEC. 306. RACIAL, ETHNIC, AND LINGUISTIC DATA COLLECTED BY THE FEDERAL GOVERNMENT.

(a) COLLECTION; SUBMISSION.—Not later than 90 days after the date of the enactment of this Act, and January 31st of each year thereafter, each department, agency, and office of the Federal Government that has collected racial, ethnic, or linguistic data during the preceding calendar year shall submit such data to the Secretary of Health and Human Services.

(b) ANALYSIS; PUBLIC AVAILABILITY; REPORTING.—Not later than April 30, 2010, and each April 30th thereafter, the Secretary of Health and Human Services, acting through the Director of the National Center on Minority

Health and Health Disparities and the Deputy Assistant Secretary for Minority Health, shall—

(1) collect and analyze the racial, ethnic, and linguistic data submitted under subsection (a) for the preceding calendar year;

(2) make publicly available such data and the results of such analysis; and

(3) submit a report to the Congress on such data and analysis.

SEC. 307. HEALTH INFORMATION TECHNOLOGY GRANTS.

(a) AUTHORITY.—The Deputy Assistant Secretary for Minority Health, in coordination with the Office of the National Coordinator for Health Information Technology, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and the National Center on Minority Health and Health Disparities, may award grants to appropriate entities for the purpose of ensuring appropriate and best practices to collect appropriate data and documents on the reduction of health disparities.

(b) USE OF FUNDS.—A grant received under subsection (a) shall be used to achieve the purpose described in such subsection through one or more of the following:

(1) Purchasing new, or enhancing existing, health information technology.

(2) Providing support and training to providers concerning such technology.

(3) Conducting outreach and education on health information technology and its benefits to patients, physicians, allied health professionals, and advocacy groups in medically underserved communities (as defined in section 799B of the Public Health Service Act (42 U.S.C. 295p)).

(c) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated $20,000,000 for each of fiscal years 2010 through 2015.

SEC. 308. STUDY OF HEALTH INFORMATION TECHNOLOGY IN MEDICALLY UNDERSERVED COMMUNITIES.

(a) STUDY.—The National Coordinator for Health Information Technology shall conduct a study on the development and implementation of health information technology in medically underserved communities. The study shall—

(1) identify barriers to successful implementation of health information technology in these communities;

(2) examine the impact of health information technology on providing quality care and reducing the cost of care to these communities;

(3) examine urban and rural community health systems and determine the impact that health information technology may have on the capacity of primary health providers; and

(4) assess the feasibility and the costs of associated with the use of health information technology in these communities.

(b) REPORT.—Not later than 18 months after the date of the enactment of this Act, the National Coordinator for Health Information Technology shall submit to the Congress a report on the study conducted under subsection (a) and shall include in such report such recommendations for legislation or administrative action as the Coordinator determines appropriate.

SEC. 309. HEALTH INFORMATION TECHNOLOGY IN MEDICALLY UNDERSERVED COMMUNITIES.

The National Coordinator for Health Information Technology shall—

(1) identify sources of funds that will be made available to promote and support the planning and adoption of health information technology in medically underserved communities (as defined in section 799B of the Public Health Service Act (42 U.S.C. 295p)), including in urban and rural areas, either through grants or technical assistance;

(2) coordinate with the funding sources to help such communities connect to identified funding; and

(3) collaborate with the Agency for Healthcare Research and Quality, the Health Resources and Services Administration, and other Federal agencies to support technical assistance, knowledge dissemination, and resource development, to such communities seeking to plan for and adopt technology and establish electronic health information networks across providers.

SEC. 310. DATA COLLECTION AND ANALYSIS GRANTS TO MINORITY-SERVING INSTITUTIONS.

(a) AUTHORITY.—The Secretary of Health and Human Services, acting through the Center on Minority Health and Health Disparities and the Office of Minority Health, may award grants to access and analyze racial and ethnic, and where possible, primary language data to monitor and report on progress to reduce and eliminate racial and ethnic disparities in health and health care.

(b) ELIGIBLE ENTITY.—In this section, the term ''eligible entity'' means a historically Black college or university, an Hispanic-serving institution, a tribal college or university, or an Asian American and Pacific Islander-serving institution with an accredited public health, health policy, or health services research program.

SEC. 311. HEALTH INFORMATION TECHNOLOGY GRANTS FOR RURAL HEALTH CARE PROVIDERS.

Title II of the Public Health Service Act is amended by adding at the end the following new part:

"PART D—HEALTH INFORMATION TECHNOLOGY GRANTS

"SEC. 271. GRANTS TO FACILITATE THE WIDESPREAD ADOPTION OF INTEROPERABLE HEALTH INFORMATION TECHNOLOGY IN RURAL AREAS.

''(a) COMPETITIVE GRANTS TO ELIGIBLE ENTITIES IN RURAL AREAS.—

''(1) IN GENERAL.—The Secretary may award competitive grants to eligible entities in rural areas to facilitate the purchase and enhance the utilization of qualified health information technology systems to improve the quality and efficiency of health care.

''(2) ELIGIBILITY.—To be eligible to receive a grant under paragraph (1) an entity shall—

''(A) submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require;

''(B) submit to the Secretary a strategic plan for the implementation of data sharing and interoperability measures;

''(C) be a rural health care provider;

''(D) adopt any applicable core interoperability guidelines (endorsed under other provisions of law);

''(E) agree to notify patients if their individually identifiable health information is wrongfully disclosed;

''(F) demonstrate significant financial need; and

''(G) provide matching funds in accordance with paragraph (4).

''(3) USE OF FUNDS.—Amounts received under a grant under this subsection shall be used to facilitate the purchase and enhance the utilization of qualified health information technology systems and training personnel in the use of such technology.

''(4) MATCHING REQUIREMENT.—To be eligible for a grant under this subsection an entity shall contribute non-Federal contributions to the costs of carrying out the activities for which the grant is awarded in an amount equal to $1 for each $3 of Federal funds provided under the grant.

''(5) LIMIT ON GRANT AMOUNT.—In no case shall the payment amount under this subsection with respect to the purchase or enhanced utilization of qualified health information technology for a rural

health care provider, in addition to the amount of any loan made to the provider from a grant to a State under subsection (b) for such purpose, exceed 100 percent of the provider's costs for such purchase or enhanced utilization (taking into account costs for training, implementation, and maintenance).

''(6) PREFERENCE IN AWARDING GRANTS.—In awarding grants to eligible entities under this subsection, the Secretary shall give preference to each of the following types of applicants:

''(A) An entity that is located in a frontier or other rural underserved area as determined by the Secretary.

''(B) An entity that will link, to the extent practicable, the qualified health information system to a local or regional health information plan or plans.

''(C) A rural health care provider that is a nonprofit hospital or a Federally qualified health center.

''(D) A rural health care provider that is an individual practice or group practice.

''(b) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—For the purpose of carrying out this section, there are authorized to be ap-

propriated $20,000,000 for fiscal year 2010, $30,000,000 for fiscal year 2011, and such sums as may be necessary, but not to exceed $30,000,000 for each of fiscal years 2012 through 2014.

''(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall remain available through fiscal year 2013.

''(c) DEFINITIONS.—In this section:

''(1) FEDERALLY QUALIFIED HEALTH CENTER.—The term 'Federally qualified health center' has the meaning given that term in section 1861(aa)(4) of the Social Security Act (42 U.S.C. 1395x(aa)(4)).

''(2) GROUP PRACTICE.—The term 'group practice' has the meaning given that term in section 1877(h)(4) of the Social Security Act (42 U.S.C. 1395nn(h)(4)).

''(3) HEALTH CARE PROVIDER.—The term 'health care provider' means a hospital, skilled nursing facility, home health agency (as defined in subsection (o) of section 1861 of the Social Security Act, 42 U.S.C. 1395x), health care clinic, rural health clinic, Federally qualified health center, group practice, a pharmacist, a pharmacy, a laboratory, a physician (as defined in subsection (r) of such sec-

tion), a practitioner (as defined in section 1842(b)(18)(CC) of such Act, 42 U.S.C. 1395u(b)(18)(CC)), a health facility operated by or pursuant to a contract with the Indian Health Service, and any other category of facility or clinician determined appropriate by the Secretary.

''(4) HEALTH INFORMATION; INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.—The terms 'health information' and 'individually identifiable health information' have the meanings given those terms in paragraphs (4) and (6), respectively, of section 1171 of the Social Security Act (42 U.S.C. 1320d).

''(5) LABORATORY.—The term 'laboratory' has the meaning given that term in section 353.

''(6) PHARMACIST.—The term 'pharmacist' has the meaning given that term in section 804(a)(2) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 384(a)(2)).

''(7) QUALIFIED HEALTH INFORMATION TECHNOLOGY.—The term 'qualified health information technology' means a system or components of health information technology that meet any applicable core interoperability guidelines (endorsed under applicable provisions of law) when in use or that use inter-

face software that allows for interoperability in accordance with such guidelines.

''(8) RURAL AREA.—The term 'rural area' has the meaning given such term for purposes of section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)).

''(9) RURAL HEALTH CARE PROVIDER.—The term 'rural health care provider' means a health care provider that is located in a rural area.''.

SEC. 312. SURVEY QUESTIONS ON SEXUAL ORIENTATION AND GENDER IDENTITY.

The Secretary of Health and Human Services, acting through the Director of the Centers for Disease Control and Prevention, shall include in the National Health Interview Survey (or any successor survey) questions to identify the sexual orientation and gender identity of individuals participating in the survey.

SEC. 313. DISAGGREGATION OF COMPARATIVE EFFECTIVENESS RESEARCH DATA.

The Secretary of Health and Human Services may not make available any Federal funds for comparative effectiveness health care research, unless the recipient of the funds agrees to ensure that the research data will be disaggregated by race, ethnicity, and gender to detect and measure differences among subpopulations.

TITLE IV—ACCOUNTABILITY AND EVALUATION

Subtitle A—General Provisions

SEC. 401. FEDERAL AGENCY PLAN TO ELIMINATE DISPARITIES AND IMPROVE THE HEALTH OF MINORITY POPULATIONS.

(a) IN GENERAL.—Not later than September 1, 2010, each Federal health agency shall develop and implement a national strategic action plan to eliminate disparities on the basis of race, ethnicity, and primary language and improve the health and health care of minority populations, through programs relevant to the mission of the agency.

(b) PUBLICATION.—Each action plan described in paragraph (1) shall—

(1) be publicly reported in draft form for public review and comment;

(2) include a response to the review and comment described in paragraph (1) in the final plan;

(3) include the agency response to the 2002 Institute of Medicine report, Unequal Treatment—Confronting Racial and Ethnic Disparities in Healthcare;

(4) respond to data and analyses presented in the National Healthcare Disparities Report and the

National Healthcare Quality Report published annually by the Agency for Healthcare Research and Quality;

(5) demonstrate progress in meeting the Healthy People 2010 objectives; and

(6) be updated, including progress reports, for inclusion in an annual report to Congress.

SEC. 402. PROHIBITION ON DISCRIMINATION IN FEDERAL ASSISTED HEALTH CARE SERVICES AND RESEARCH PROGRAMS ON THE BASIS OF SEX, RACE, COLOR, NATIONAL ORIGIN, SEXUAL ORIENTATION, GENDER IDENTITY, OR DISABILITY STATUS.

No person in the United States shall, on the basis of sex, race, color, national origin, sexual orientation, gender identity, or disability status, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health care service or research program or activity receiving Federal financial assistance.

SEC. 403. ACCOUNTABILITY WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Title XXXI of the Public Health Service Act, as amended by titles II and III of this Act, is further amended by adding at the end the following:

"Subtitle C—Strengthening Accountability

"SEC. 3141. ELEVATION OF THE OFFICE OF CIVIL RIGHTS.

''(a) IN GENERAL.—The Secretary shall establish within the Office for Civil Rights an Office of Health Disparities, which shall be headed by a director to be appointed by the Secretary.

''(b) PURPOSE.—The Office of Health Disparities shall ensure that the health programs, activities, and operations of health entities which receive Federal financial assistance are in compliance with title VI of the Civil Rights Act, which prohibits discrimination on the basis of race, color, or national origin. The activities of the Office shall include the following:

''(1) The development and implementation of an action plan to address racial and ethnic health care disparities, which shall address concerns relating to the Office for Civil Rights as released by the United States Commission on Civil Rights in the report entitled 'Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equity' (September, 1999) in conjunction with the reports by the Institute of Medicine entitled 'Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care', 'Crossing the Quality

Chasm: A New Health System for the 21st Century', and 'In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce' and other related reports by the Institute of Medicine. This plan shall be publicly disclosed for review and comment and the final plan shall address any comments or concerns that are received by the Office.

''(2) Investigative and enforcement actions against intentional discrimination and policies and practices that have a disparate impact on minorities.

''(3) The review of racial, ethnic, and primary language health data collected by Federal health agencies to assess health care disparities related to intentional discrimination and policies and practices that have a disparate impact on minorities.

''(4) Outreach and education activities relating to compliance with title VI of the Civil Rights Act.

''(5) The provision of technical assistance for health entities to facilitate compliance with title VI of the Civil Rights Act.

''(6) Coordination and oversight of activities of the civil rights compliance offices established under section 3142.

''(7) Ensuring compliance with the 1997 Office of Management and Budget Standards for Maintain-

ing, Collecting, and Presenting Federal Data on Race, Ethnicity and the available language standards.

''(c) FUNDING AND STAFF.—The Secretary shall ensure the effectiveness of the Office of Health Disparities by ensuring that the Office is provided with—

''(1) adequate funding to enable the Office to carry out its duties under this section; and

''(2) staff with expertise in—

''(A) epidemiology;

''(B) statistics;

''(C) health quality assurance;

''(D) minority health and health disparities;

''(E) cultural and linguistic competency; and

''(F) civil rights.

''(d) REPORT.—Not later than December 31, 2010, and annually thereafter, the Secretary, in collaboration with the Director of the Office for Civil Rights and the Director of the Office of Minority Health, shall submit a report to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives that includes—

''(1) the number of cases filed, broken down by category;

''(2) the number of cases investigated and closed by the office;

''(3) the outcomes of cases investigated;

''(4) the staffing levels of the office including staff credentials;

''(5) the number of other lingering and emerging cases in which civil rights inequities can be demonstrated; and

''(6) the number of cases remaining open and an explanation for their open status.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

''SEC. 3142. ESTABLISHMENT OF HEALTH PROGRAM OFFICES FOR CIVIL RIGHTS WITHIN FEDERAL HEALTH AND HUMAN SERVICES AGENCIES.

''(a) IN GENERAL.—The Secretary shall establish civil rights compliance offices in each agency within the Department of Health and Human Services that administers health programs.

''(b) PURPOSE OF OFFICES.—Each office established under subsection (a) shall ensure that recipients of Fed-

eral financial assistance under Federal health programs administer their programs, services, and activities in a manner that—

''(1) does not discriminate, either intentionally or in effect, on the basis of race, national origin, language, ethnicity, sex, age, or disability; and

''(2) promotes the reduction and elimination of disparities in health and health care based on race, national origin, language, ethnicity, sex, age, and disability.

''(c) POWERS AND DUTIES.—The offices established in subsection (a) shall have the following powers and duties:

''(1) The establishment of compliance and program participation standards for recipients of Federal financial assistance under each program administered by an agency within the Department of Health and Human Services including the establishment of disparity reduction standards to encompass disparities in health and health care related to race, national origin, language, ethnicity, sex, age, and disability.

''(2) The development and implementation of program-specific guidelines that interpret and apply Department of Health and Human Services guid-

ance under title VI of the Civil Rights Act of 1964 to each Federal health program administered by the agency.

''(3) The development of a disparity-reduction impact analysis methodology that shall be applied to every rule issued by the agency and published as part of the formal rulemaking process under sections 555, 556, and 557 of title 5, United States Code.

''(4) Oversight of data collection, analysis, and publication requirements for all recipients of Federal financial assistance under each Federal health program administered by the agency, and compliance with the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity and the available language standards.

''(5) The conduct of publicly available studies regarding discrimination within Federal health programs administered by the agency as well as disparity reduction initiatives by recipients of Federal financial assistance under Federal health programs.

''(6) Annual reports to the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate and the Committee on Energy and Commerce and the Committee

on Ways and Means of the House of Representatives on the progress in reducing disparities in health and health care through the Federal programs administered by the agency.

''(d) RELATIONSHIP TO OFFICE FOR CIVIL RIGHTS IN THE DEPARTMENT OF JUSTICE.—

''(1) DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The Office for Civil Rights in the Department of Health and Human Services shall provide standard-setting and compliance review investigation support services to the Civil Rights Compliance Office for each agency.

''(2) DEPARTMENT OF JUSTICE.—The Office for Civil Rights in the Department of Justice shall continue to maintain the power to institute formal proceedings when an agency Office for Civil Rights determines that a recipient of Federal financial assistance is not in compliance with the disparity reduction standards of the agency.

''(e) DEFINITION.—In this section, the term 'Federal health programs' mean programs—

''(1) under the Social Security Act (42 U.S.C. 301 et seq.) that pay for health care and services; and

''(2) under this Act that provide Federal financial assistance for health care, biomedical research, health services research, and programs designed to improve the public's health.''.

SEC. 404. OFFICE OF MINORITY HEALTH.

Section 1707 of the Public Health Service Act (42 U.S.C. 300u–6) is amended—

(1) by striking subsection (b) and inserting the following:

''(b) DUTIES.—With respect to improving the health of racial and ethnic minority groups, the Secretary, acting through the Deputy Assistant Secretary for Minority Health (in this section referred to as the 'Deputy Assistant Secretary'), shall carry out the following:

''(1) Establish, implement, monitor, and evaluate short-range and long-range goals and objectives and oversee all other activities within the Public Health Service that relate to disease prevention, health promotion, service delivery, and research concerning minority groups. The heads of each of the agencies of the Service shall consult with the Deputy Assistant Secretary to ensure the coordination of such activities.

''(2) Oversee all activities within the Department of Health and Human Services that relate to

reducing or eliminating disparities in health and health care in racial and ethnic minority populations and in rural and underserved communities, including coordinating—

"(A) the design of programs, support for programs, and the evaluation of programs;

"(B) the monitoring of trends in health and health care;

"(C) research efforts;

"(D) the training of health providers; and

"(E) information and education programs and campaigns.

"(3) Enter into interagency and intra-agency agreements with other agencies of the Public Health Service.

"(4) Ensure that the Federal health agencies and the National Center for Health Statistics collect data on the health status and health care of each minority group, using at a minimum the categories specified in the 1997 OMB Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity as required under subtitle B and available language standards.

"(5) Provide technical assistance to States, local agencies, territories, Indian tribes, and entities

for activities relating to the elimination of racial and ethnic disparities in health and health care.

''(6) Support a national minority health resource center to carry out the following:

''(A) Facilitate the exchange of information regarding matters relating to health information, health promotion and wellness, preventive health services, clinical trials, health information technology, and education in the appropriate use of health services.

''(B) Facilitate timely access to culturally and linguistically appropriate information.

''(C) Assist in the analysis of such information.

''(D) Provide technical assistance with respect to the exchange of such information (including facilitating the development of materials for such technical assistance).

''(7) Carry out programs to improve access to health care services for individuals with limited English proficiency, including developing and carrying out programs to provide bilingual or interpretive services through the development and support of the Robert T. Matsui Center for Cultural and Lin-

guistic Competence in Health Care as provided for in section 3103.

''(8) Carry out programs to improve access to health care services and to improve the quality of health care services for individuals with low functional health literacy. As used in the preceding sentence, the term 'functional health literacy' means the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

''(9) Advise in matters related to the development, implementation, and evaluation of health professions education on decreasing disparities in health care outcomes, with focus on cultural competency as a method of eliminating disparities in health and health care in racial and ethnic minority populations.

''(10) Assist health care professionals, community and advocacy organizations, academic centers and public health departments in the design and implementation of programs that will improve the quality of health outcomes by strengthening the provider-patient relationship.'';

(2) by redesignating subsections (f) through (h) as subsections (g) through (i), respectively;

(3) by inserting after subsection (d) the following:

''(f) PREPARATION OF HEALTH PROFESSIONALS TO PROVIDE HEALTH CARE TO MINORITY POPULATIONS.—The Secretary, in collaboration with the Director of the Bureau of Health Professions and the Deputy Assistant Secretary for Minority Health, shall require that health professional schools that receive Federal funds train future health professionals to provide culturally and linguistically appropriate health care to diverse populations.''; and

(4) by striking subsection (i) (as so redesignated) and inserting the following:

''(i) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $100,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2015.''.

SEC. 405. ESTABLISHMENT OF THE INDIAN HEALTH SERVICE AS AN AGENCY OF THE PUBLIC HEALTH SERVICE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—In order to more effectively and efficiently carry out the responsibilities, authorities, and functions of the United States to provide

health care services to Indians and Indian tribes, as are or may be hereafter provided by Federal statute or treaties, there is established within the Public Health Service of the Department of Health and Human Services the Indian Health Service.

(2) ASSISTANT SECRETARY OF INDIAN HEALTH.—The Service shall be administered by an Assistant Secretary of Indian Health, who shall be appointed by the President, by and with the advice and consent of the Senate. The Assistant Secretary shall report to the Secretary. Effective with respect to an individual appointed by the President, by and with the advice and consent of the Senate the term of service of the Assistant Secretary shall be 4 years. An Assistant Secretary may serve more than 1 term.

(b) AGENCY.—The Service shall be an agency within the Public Health Service of the Department, and shall not be an office, component, or unit of any other agency of the Department.

(c) FUNCTIONS AND DUTIES.—The Secretary shall carry out through the Assistant Secretary of the Service—

(1) all functions which were, on the day before the date of enactment of the Indian Health Care Amendments of 1988, carried out by or under the

direction of the individual serving as Director of the Service on such day;

(2) all functions of the Secretary relating to the maintenance and operation of hospital and health facilities for Indians and the planning for, and provision and utilization of, health services for Indians;

(3) all health programs under which health care is provided to Indians based upon their status as Indians which are administered by the Secretary, including programs under—

(A) the Indian Health Care Improvement Act;

(B) the Act of November 2, 1921 (25 U.S.C. 13);

(C) the Act of August 5, 1954 (42 U.S.C. 2001 et seq.);

(D) the Act of August 16, 1957 (42 U.S.C. 2005 et seq.);

(E) the Indian Self-Determination Act (25 U.S.C. 450f et seq.); and

(F) title XXXI of the Public Health Service Act, as added by this Act; and

(4) all scholarship and loan functions carried out under title I of the Indian Health Care Improvement Act.

(d) AUTHORITY.—

(1) IN GENERAL.—The Secretary, acting through the Assistant Secretary, shall have the authority—

(A) except to the extent provided for in paragraph (2), to appoint and compensate employees for the Service in accordance with title 5, United States Code;

(B) to enter into contracts for the procurement of goods and services to carry out the functions of the Service; and

(C) to manage, expend, and obligate all funds appropriated for the Service.

(2) PERSONNEL ACTIONS.—Notwithstanding any other provision of law, the provisions of section 12 of the Act of June 18, 1934 (48 Stat. 986; 25 U.S.C. 472), shall apply to all personnel actions taken with respect to new positions created within the Service as a result of its establishment under subsection (a).

(e) RATE OF PAY.—

(1) POSITIONS AT LEVEL IV.—Section 5315 of title 5, United States Code, is amended by striking the following: ''Assistant Secretaries of Health and

Human Services (6).'' and inserting ''Assistant Secretaries of Health and Human Services (7).''.

(2) POSITIONS AT LEVEL V.—Section 5316 of such title is amended by striking the following: ''Director, Indian Health Service, Department of Health and Human Services.''.

(f) DUTIES OF ASSISTANT SECRETARY FOR INDIAN HEALTH.—Section 601 of the Indian Health Care Improvement Act (25 U.S.C. 1661) is amended in subsection (a)—

(1) by inserting ''(1)'' after ''(a)'';

(2) in the second sentence of paragraph (1), as so designated, by striking ''a Director,'' and inserting ''the Assistant Secretary for Indian Health,'';

(3) by striking the third sentence of paragraph (1), as so designated, and all that follows through the end of the subsection (a) of such section and inserting the following: ''The Assistant Secretary for Indian Health shall carry out the duties specified in paragraph (2).''; and

(4) by adding after paragraph (1) the following:

''(2) The Assistant Secretary for Indian Health shall—

''(A) report directly to the secretary concerning all policy and budget-related matters affecting Indian health;

''(B) collaborate with the Assistant Secretary for Health concerning appropriate matters of Indian health that affect the agencies of the Public Health Service;

''(C) advise each Assistant Secretary of the Department of Health and Human Services concerning matters of Indian health with respect to which that Assistant Secretary has authority and responsibility;

''(D) advise the heads of other agencies and programs of the Department of Health and Human Services concerning matters of Indian health with respect to which those heads have authority and responsibility; and

''(E) coordinate the activities of the Department of Health and Human Services concerning matters of Indian health.''.

(g) CONTINUED SERVICE BY INCUMBENT.—The individual serving in the position of Director of the Indian Health Service on the date preceding the date of enactment of this Act may serve as Assistant Secretary for In-

dian Health, at the pleasure of the President after the date of enactment of this Act.

(h) CONFORMING AMENDMENTS.—

(1) AMENDMENTS TO INDIAN HEALTH CARE IMPROVEMENT ACT.—The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.) is amended—

(A) in section 601—

(i) in subsection (c), by striking ''Director of the Indian Health Service'' both places it appears and inserting ''Assistant Secretary for Indian Health''; and

(ii) in subsection (d), by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''; and

(B) in section 816(c)(1), by striking ''Director of the Indian Health Service'' and inserting ''Assistant Secretary for Indian Health''.

(2) AMENDMENTS TO OTHER PROVISIONS OF LAW.—The following provisions are each amended by striking ''Director of the Indian Health Service'' each place it appears and inserting ''Assistant Secretary for Indian Health'':

(A) Section 203(a)(1) of the Rehabilitation Act of 1973 (29 U.S.C. 763(a)(1)).

(B) Subsections (b) and (e) of section 518 of the Federal Water Pollution Control Act (33 U.S.C. 1377 (b) and (e)).

(C) Section 803B(d)(1) of the Native American Programs Act of 1974 (42 U.S.C. 2991b–2(d)(1)).

(i) REFERENCES.—Reference in any other Federal law, Executive order, rule, regulation, or delegation of authority, or any document of or relating to the Director of the Indian Health Service shall be deemed to refer to the Assistant Secretary for Indian Health.

(j) DEFINITIONS.—For purposes of this section, the definitions contained in section 4 of the Indian Health Care Improvement Act shall apply.

SEC. 406. ESTABLISHMENT OF INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN AGENCIES OF THE PUBLIC HEALTH SERVICE.

Title XVII of the Public Health Service Act (42 U.S.C. 300u et seq.) is amended by inserting after section 1707 the following section:

''INDIVIDUAL OFFICES OF MINORITY HEALTH WITHIN PUBLIC HEALTH SERVICE

''SEC. 1707A.

''(a) IN GENERAL.—The head of each agency specified in subsection (b)(1) shall establish within the agency an office to be known as the Office of Minority Health. Each such Office shall be headed by a director, who shall be appointed by the head of the agency within which the Office is established, and who shall report directly to the head of the agency. The head of such agency shall carry out this section (as this section relates to the agency) acting through such Director.

''(b) SPECIFIED AGENCIES.—

''(1) IN GENERAL.—The agencies referred to in subsection (a) are the following:

''(A) The Centers for Disease Control and Prevention.

''(B) The Health Resources and Services Administration.

''(C) The Substance Abuse and Mental Health Services Administration.

''(D) The Administration on Aging.

''(c) COMPOSITION.—The head of each specified agency shall ensure that the officers and employees of the minority health office of the agency are, collectively, experienced in carrying out community-based health programs for each of the various racial and ethnic minority groups

that are present in significant numbers in the United States.

''(d) DUTIES.—Each Director of a minority health office shall establish and monitor the programs of the specified agency of such office in order to carry out the following:

''(1) Determine the extent to which the purposes of the programs are being carried out with respect to racial and ethnic minority groups;

''(2) Determine the extent to which members of such groups are represented among the Federal officers and employees who administer the programs; and

''(3) Make recommendations to the head of such agency on carrying out the programs with respect to such groups. In the case of programs that provide services, such recommendations shall include recommendations toward ensuring that—

''(A) the services are equitably delivered with respect to racial and ethnic minority groups;

''(B) the programs provide the services in the language and cultural context that is most appropriate for the individuals for whom the services are intended; and

''(C) the programs utilize racial and ethnic minority community-based organizations to deliver services.

''(e) BIENNIAL REPORTS TO SECRETARY.—The head of each specified agency shall submit to the Secretary for inclusion in each biennial report describing—

''(1) the extent to which the minority health office of the agency employs individuals who are members of racial and ethnic minority groups, including a specification by minority group of the number of such individuals employed by such office.

''(f) FUNDING.—

''(1) ALLOCATIONS.—Of the amounts appropriated for a specified agency for a fiscal year, the Secretary must designate an appropriate amount of funds for the purpose of carrying out activities under this section through the minority health office of the agency. In reserving an amount under the preceding sentence for a minority health office for a fiscal year, the Secretary shall reduce, by substantially the same percentage, the amount that otherwise would be available for each of the programs of the designated agency involved.

''(2) AVAILABILITY OF FUNDS FOR STAFFING.—The purposes for which amounts made avail-

able under paragraph may be expended by a minority health office include the costs of employing staff for such office.''.

SEC. 407. OFFICE OF MINORITY HEALTH AT THE CENTERS FOR MEDICARE & MEDICAID SERVICES.

(a) IN GENERAL.—Not later than 60 days after the date of enactment of this Act, the Secretary of Health and Human Services shall establish within the Centers for Medicare & Medicaid Services an Office of Minority Health (referred to in this section as the ''Office'').

(b) DUTIES.—The Office shall be responsible for the coordination and facilitation of activities of the Centers for Medicare & Medicaid Services to improve minority health and health care and to reduce racial and ethnic disparities in health and health care, which shall include—

(1) creating a strategic plan, which shall be made available for public review, to improve the health and health care of Medicare, Medicaid, and SCHIP beneficiaries;

(2) promoting agency-wide policies relating to health care delivery and financing that could have a beneficial impact on the health and health care of minority populations;

(3) assisting health plans, hospitals, and other health entities in providing culturally and linguistically appropriate health care services;

(4) increasing awareness and outreach activities for minority health care consumers and providers about the causes and remedies for health and health care disparities;

(5) developing grant programs and demonstration projects to identify, implement and evaluate innovative approaches to improving the health and health care of minority beneficiaries in the Medicare, Medicaid, and SCHIP programs;

(6) considering incentive programs relating to reimbursement that would reward health entities for providing quality health care for minority populations using established benchmarks for quality of care;

(7) collaborating with the compliance office to ensure compliance with the anti-discrimination provisions under title VI of the Civil Rights Act of 1964;

(8) identifying barriers to enrollment in public programs under the jurisdiction of the Centers for Medicare & Medicaid Services;

(9) monitoring and evaluating on a regular basis the success of minority health programs and initiatives;

(10) publishing an annual report about the activities of the Centers for Medicare & Medicaid Services relating to minority health improvement; and

(11) other activities determined appropriate by the Secretary of Health and Human Services.

(c) STAFF.—The staff at the Office shall include—

(1) one or more individuals with expertise in minority health and racial and ethnic health disparities; and

(2) one or more individuals with expertise in health care financing and delivery in underserved communities.

(d) COORDINATION.—In carrying out its duties under this section, the Office shall coordinate with—

(1) the Office of Minority Health in the Office of the Secretary of Health and Human Services;

(2) the National Centers for Minority Health and Health Disparities in the National Institutes of Health; and

(3) the Office of Minority Health in the Centers for Disease Control and Prevention.

(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated $10,000,000 for fiscal year 2010, and such sums may be necessary for each of fiscal years 2011 through 2016.

SEC. 408. OFFICE OF MINORITY AFFAIRS AT THE FOOD AND DRUG ADMINISTRATION.

Chapter IX of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 391 et seq.) is amended by adding at the end the following:

"SEC. 911. OFFICE OF MINORITY AFFAIRS.

''(a) IN GENERAL.—Not later than 60 days after the date of enactment of this section, the Secretary shall establish within the Office of the Commissioner of Food and Drugs an Office of Minority Affairs (referred to in this section as the 'Office').

''(b) DUTIES.—The Office shall be responsible for the coordination and facilitation of activities of the Food and Drug Administration to improve minority health and health care and to reduce racial and ethnic disparities in health and health care, which shall include—

''(1) promoting policies in the development and review of medical products that reduce racial and ethnic disparities in health and health care;

''(2) encouraging appropriate data collection, analysis, and dissemination of racial and ethnic differences using, at a minimum, the categories described in the 1997 Office of Management and Budget standards, in response to different therapies in both adult and pediatric populations;

''(3) providing, in coordination with other appropriate government agencies, education, training, and support to increase participation of minority patients and physicians in clinical trials;

''(4) collecting and analyzing data using, at a minimum, the categories described in the 1997 Office of Management and Budget standards, on the number of participants from minority racial and ethnic backgrounds in clinical trials used to support medical product approvals;

''(5) the identification of methods to reduce language and literacy barriers; and

''(6) publishing an annual report about the activities of the Food and Drug Administration pertaining to minority health.

''(c) STAFF.—The staff of the Office shall include—

''(1) one or more individuals with expertise in the design and conduct of clinical trials of drugs, biological products, and medical devices; and

''(2) one or more individuals with expertise in therapeutic classes or disease states for which medical evidence suggests a difference based on race or ethnicity.

''(d) COORDINATION.—In carrying out its duties under this section, the Office shall coordinate with—

''(1) the Office of Minority Health in the Office of the Secretary of Health and Human Services;

''(2) the National Institute for Minority Health and Health Disparities in the National Institutes of Health; and

''(3) the Office of Minority Health in the Centers for Disease Control and Prevention.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2010 through 2015.''.

SEC. 409. SAFETY AND EFFECTIVENESS OF DRUGS WITH RESPECT TO RACIAL AND ETHNIC BACKGROUND.

(a) IN GENERAL.—Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by adding after section 505D the following:

"SEC. 505E. SAFETY AND EFFECTIVENESS OF DRUGS WITH RESPECT TO RACIAL AND ETHNIC BACKGROUND.

''(a) PRE-APPROVAL STUDIES.—If there is evidence that there may be a disparity on the basis of racial or ethnic background as to the safety or effectiveness of a drug, then—

''(1)(A) the investigations required under section 505(b)(1)(A) shall include adequate and well-controlled investigations of the disparity; or

''(B) the evidence required under section 351(a) of the Public Health Service Act for approval of a biologics license application for the drug shall include adequate and well-controlled investigations of the disparity; and

''(2) if the investigations confirm that there is a disparity, the labeling of the drug shall include appropriate information about the disparity.

''(b) POST-MARKET STUDIES.—

''(1) IN GENERAL.—If there is evidence that there may be a disparity on the basis of racial or ethnic background as to the safety or effectiveness of a drug for which there is an approved application under section 505 or a license under section 351 of the Public Health Service Act, the Secretary may by order require the holder of the approved application

or license to conduct, by a date specified by the Secretary, post-marketing studies to investigate the disparity.

''(2) LABELING.—If the Secretary determines that the post-market studies confirm that there is a disparity described in paragraph (1), the labeling of the drug shall include appropriate information about the disparity.

''(3) STUDY DESIGN.—The Secretary may specify all aspects of study design, including the number of studies and study participants, in the order requiring post-market studies of the drug.

''(4) MODIFICATIONS OF STUDY DESIGN.—The Secretary may by order modify any aspect of the study design as necessary after issuing an order under paragraph (1).

''(5) STUDY RESULTS.—The results from studies required under paragraph (1) shall be submitted to the Secretary as supplements to the drug application or biological license application.

''(c) DISPARITY.—The term 'evidence that there may be a disparity on the basis of racial or ethnic background for adult and pediatric populations as to the safety or effectiveness of a drug' includes—

''(1) evidence that there is a disparity on the basis of racial or ethnic background as to safety or effectiveness of a drug in the same chemical class as the drug;

''(2) evidence that there is a disparity on the basis of racial or ethnic background in the way the drug is metabolized; and

''(3) other evidence as the Secretary may determine.

''(d) APPLICATIONS UNDER SECTION 505(b)(2) AND 505(j).—

''(1) IN GENERAL.—A drug for which an application has been submitted or approved under section 505(j) shall not be considered ineligible for approval under that section or misbranded under section 502 on the basis that the labeling of the drug omits information relating to a disparity on the basis of racial or ethnic background as to the safety or effectiveness of the drug, whether derived from investigations or studies required under this section or derived from other sources, when the omitted information is protected by patent or by exclusivity under clause (iii) or (iv) of section 505(j)(5)(B).

''(2) LABELING.—Notwithstanding clauses (iii) and (iv) of section 505(j)(5)(B), the Secretary may

require that the labeling of a drug approved under section 505(j) that omits information relating to a disparity on the basis of racial or ethnic background as to the safety or effectiveness of the drug include a statement of any appropriate contraindications, warnings, or precautions related to the disparity that the Secretary considers necessary.''.

(b) ENFORCEMENT.—Section 502 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 352) is amended by adding at the end the following:

''(aa) If it is a drug and the holder of the approved application under section 505 or license under section 351 of the Public Health Service Act for the drug has failed to complete the investigations or studies, or comply with any other requirement, of section 505E.''.

(c) DRUG FEES.—Section 736(a)(1)(A)(ii) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 379h) is amended by adding after ''are required'' the following: '', including supplements required under section 505E''.

SEC. 410. UNITED STATES COMMISSION ON CIVIL RIGHTS.

(a) COORDINATION WITHIN DEPARTMENT OF JUSTICE OF ACTIVITIES REGARDING HEALTH DISPARITIES.—Section 3 of the Civil Rights Commission Act of 1983 (42 U.S.C. 1975a) is amended—

(1) in paragraph (1)(B), by striking ''and'' at the end;

(2) in paragraph (2), in the matter after and below subparagraph (D), by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(3) shall, with respect to activities carried out in health care and correctional facilities toward the goal of eliminating health disparities between the general population and members of racial or ethnic minority groups, coordinate such activities of—

''(A) the Office for Civil Rights within the Department of Justice;

''(B) the Office of Justice Programs within the Department of Justice;

''(C) the Office for Civil Rights within the Department of Health and Human Services; and

''(D) the Office of Minority Health within the Department of Health and Human Services (headed by the Deputy Assistant Secretary for Minority Health).''.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 5 of the Civil Rights Commission Act of 1983 (42 U.S.C. 1975c) is amended by striking the first sentence and in-

serting the following: ''For the purpose of carrying out this Act, there are authorized to be appropriated $30,000,000 for fiscal year 2010, and such sums as may be necessary for each of the fiscal years 2011 through 2015.''.

SEC. 411. SENSE OF CONGRESS CONCERNING FULL FUNDING OF ACTIVITIES TO ELIMINATE RACIAL AND ETHNIC HEALTH DISPARITIES.

(a) FINDINGS.—Congress makes the following findings:

(1) The health status of the American populace is declining and the United States currently ranks below most industrialized nations in health status measured by longevity, sickness, and mortality.

(2) Racial and ethnic minority populations tend have the poorest health status and face substantial cultural, social, and economic barriers to obtaining quality health care.

(3) Efforts to improve minority health have been limited by inadequate resources (funding, staffing, and stewardship) and accountability.

(b) SENSE OF CONGRESS.—It is the sense of Congress that—

(1) funding should be doubled by fiscal year 2010 for the National Institute for Minority Health

Disparities, the Office of Civil Rights in the Department of Health and Human Services, the National Institute of Nursing Research, and the Office of Minority Health;

(2) adequate funding by fiscal year 2010, and subsequent funding increases, should be provided for health professions training programs, the Racial and Ethnic Approaches to Community Health (REACH) at the Center for Disease Control and Prevention, the Minority HIV/AIDS Initiative, and the Excellence Centers to Eliminate Ethnic/Racial Disparities (EXCEED) Program at the Agency for Healthcare Research and Quality;

(3) current and newly created health disparity elimination incentives, programs, agencies, and departments under this Act (and the amendments made by this Act) should receive adequate staffing and funding by fiscal year 2010; and

(4) stewardship and accountability should be provided to Congress and the President for measurable and sustainable progress toward health disparity elimination.

SEC. 412. GUIDELINES FOR DISEASE SCREENING FOR MINORITY PATIENTS.

(a) IN GENERAL.—The Secretary, acting through the Director of the Agency for Healthcare Research and Quality, shall convene a series of meetings to develop guidelines for disease screening for minority patient populations which have a higher than average risk for many chronic diseases and cancers.

(b) PARTICIPANTS.—In convening meetings under subsection (a), the Secretary shall ensure that meeting participants include representatives of—

(1) professional societies and associations;

(2) minority health organizations;

(3) health care researchers and providers, including those with expertise in minority health;

(4) Federal health agencies, including the Office of Minority Health, the National Center on Minority Health and Health Disparities, and the National Institutes of Health; and

(5) other experts determined appropriate by the Secretary.

(c) DISEASES.—Screening guidelines for minority populations shall be developed under subsection (a) for—

(1) hypertension;

(2) hypercholesterolemia;

(3) diabetes;

(4) cardiovascular disease;

(5) cancers, including breast, prostate, colon, cervical, and lung cancer;

(6) asthma;

(7) diabetes;

(8) kidney diseases;

(9) eye diseases and disorders, including glaucoma;

(10) HIV/AIDS and sexually transmitted diseases;

(11) uterine fibroids;

(12) autoimmune disease;

(13) mental health conditions;

(14) dental health conditions and oral diseases;

(15) environmental and related health illnesses and conditions;

(16) Sickle cell disease;

(17) violence and injury prevention and control;

(18) genetic and related conditions;

(19) heart disease and stroke;

(20) tuberculosis;

(21) chronic obstructive pulmonary disease; and

(22) other diseases determined appropriate by the Secretary.

(d) DISSEMINATION.—Not later than 24 months after the date of enactment of this title, the Secretary shall publish and disseminate to health care provider organizations the guidelines developed under subsection (a).

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, sums as may be necessary for each of fiscal years 2010 through 2015.

SEC. 413. NATIONAL INSTITUTE FOR MINORITY HEALTH AND HEALTH DISPARITIES.

(a) REDESIGNATION.—

(1) IN GENERAL.—Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.) is amended—

(A) in section 401(b)(24), by striking ''National Center on Minority Health and Health Disparities'' and inserting ''National Institute for Minority Health and Health Disparities''; and

(B) in subpart 6 of part E—

(i) in the subpart heading, by striking ''Center'' and inserting ''Institute'';

(ii) in the headings of sections 485E and 485H, by striking ''**CENTER**'' and inserting ''**INSTITUTE**''; and

(iii) by striking (other than in section 485E(i)(1)) the term ''Center'' each place it appears and inserting ''Institute''.

(2) REFERENCES.—Any reference in any law, map, regulation, document, paper, or other record of the United States to the National Center on Minority Health and Health Disparities shall be deemed to be a reference to the National Institute for Minority Health and Health Disparities.

(b) DUTIES; AUTHORITIES; FUNDING.—Section 485E of the Public Health Service Act (42 U.S.C. 287c–31) is amended—

(1) by amending subsection (e) to read as follows:

''(e) DUTIES OF THE DIRECTOR.—

''(1) INTERAGENCY COORDINATION OF MINORITY HEALTH AND HEALTH DISPARITY ACTIVITIES.—With respect to minority health and health disparities, the Director of the Institute shall plan, coordinate, and evaluate research and other activities conducted or supported by the institutes and centers of the National Institutes of Health. In carrying out the preceding sentence, the Director of the Institute shall evaluate the minority health and health disparity activities of each of such institutes and cen-

ters and shall provide for the periodic reevaluation of such activities. Such institutes and centers shall be responsible for providing information to the Institute, including data on clinical trials funded or conducted by these institutes and centers.

''(2) CONSULTATIONS.—The Director of the Institute shall carry out this subpart (including developing and revising the plan and budget required by subsection (f) in consultation with the heads of the institutes and centers of the National Institutes of Health, the advisory councils of such institutes and centers, and the advisory council established pursuant to subsection (j).

''(3) COORDINATION OF ACTIVITIES.—The Director of the Institute—

''(A) shall act as the primary Federal official with responsibility for coordinating all research and activities conducted or supported by the National Institutes of Health on minority or other health disparities;

''(B) shall represent the health disparities research program of the National Institutes of Health, including the minority health and other health disparities research program, at all rel-

evant executive branch task forces, committees, and planning activities; and

''(C) shall maintain communications with all relevant agencies of the Public Health Service, including the Indian Health Service, and various other departments and agencies of the Federal Government to ensure the timely transmission of information concerning advances in minority health disparities research and other health disparities research among these various agencies for dissemination to affected communities and health care providers.'';

(2) by amending subsection (f) to read as follows:

''(f) STRATEGIC PLAN.—

''(1) IN GENERAL.—Subject to the provisions of this section and other applicable law, the Director of the Institute, in consultation with the Director of NIH, the Directors of the other institutes and centers of the National Institutes of Health, and the advisory council established pursuant to subsection (j), shall—

''(A) annually review and revise a strategic plan (referred to in this section as 'the plan') and budget for the conduct and support of all

minority health disparity research and other health disparity research activities of the institutes and centers of the National Institutes of Health that include time-based targeted objectives with measurable outcomes and assure that the annual review and revision of the plan uses an established trans-National Institutes of Health process subject to timely review, approval, and dissemination;

''(B) ensure that the plan and budget establish priorities among the health disparities research activities that such agencies are authorized to carry out;

''(C) ensure that the plan and budget establish objectives regarding such activities, describe the means for achieving the objectives, and designate the date by which the objectives are expected to be achieved;

''(D) ensure that all amounts appropriated for such activities are expended in accordance with the plan and budget;

''(E) annually submit to Congress a report on the progress made with respect to the plan; and

''(F) create and implement a plan for the systemic review of research activities supported by the National Institutes of Health that are within the mission of both the Institute and other institutes and centers of the National Institutes of Health, including by establishing mechanisms for—

''(i) tracking minority health and health disparity research conducted within the institutes and centers assessing the appropriateness of this research with regard to the overall goals and objectives of the plan;

''(ii) the early identification of applications and proposals for grants, contracts, and cooperative agreements supporting extramural training, research, and development, that are submitted to the institutes and centers that are within the mission of the Institute;

''(iii) providing the Institute with the written descriptions and scientific peer review results of such applications and proposals;

"(iv) enabling the institutes and centers to consult with the Director of the Institute prior to final approval of such applications and proposals; and

"(v) reporting to the Director of the Institute all such applications and proposals that are approved for funding by the institutes and centers.

"(2) CERTAIN COMPONENTS OF PLAN AND BUDGET.—With respect to health disparities research activities of the agencies of the National Institutes of Health, the Director of the Institute shall ensure that the plan and budget under paragraph (1) provide for—

"(A) basic research and applied research, including research and development with respect to products;

"(B) research that is conducted by the agencies;

"(C) research that is supported by the agencies;

"(D) proposals developed pursuant to solicitations by the agencies and for proposals developed independently of such solicitations; and

''(E) behavioral research and social sciences research, which may include cultural and linguistic research in each of the agencies.

''(3) MINORITY HEALTH DISPARITIES RESEARCH.—The plan and budget under paragraph (1) shall include a separate statement of the plan and budget for minority health disparities research.'';

(3) by amending subsection (h) to read as follows:

''(h) RESEARCH ENDOWMENTS.—

''(1) IN GENERAL.—The Director of the Institute shall carry out a program to facilitate minority health and health disparities research and other health disparities research by providing research endowments at—

''(A) centers of excellence under section 736; and

''(B) centers of excellence under section 485F.

''(2) ELIGIBILITY.—The Director of the Institute shall provide for a research endowment under paragraph (1) only if the institution involved meets the following conditions:

''(A) The institution does not have an endowment that is worth in excess of an amount

equal to 50 percent of the national average of endowment funds at institutions that conduct similar biomedical research or training of health professionals.

''(B) The application of the institution under paragraph (1) regarding a research endowment has been recommended pursuant to technical and scientific peer review and has been approved by the advisory council established pursuant to subsection (j).

''(C) The institution at any time was deemed to be eligible to receive a grant under section 736 and at any time received a research endowment under paragraph (1).''; and

(4) by adding at the end the following:

''(k) FUNDING.—

''(1) FULL FUNDING BUDGET.—

''(A) IN GENERAL.—With respect to a fiscal year, the Director of the Institute shall prepare and submit directly to the President, for review and transmittal to Congress, a budget estimate for carrying out the plan for the fiscal year, after reasonable opportunity for comment (but without change) by the Secretary, the Director of the National Institutes of Health, the

directors of the other institutes and centers of the National Institutes of Health, and the advisory council established pursuant to subsection (j). The budget estimate shall include an estimate of the number and type of personnel needs for the Institute.

''(B) AMOUNTS NECESSARY.—The budget estimate submitted under subparagraph (A) shall estimate the amounts necessary for the institutes and centers of the National Institutes of Health to carry out all minority health and health disparities activities determined by the Director of the Institute to be appropriate, without regard to the probability that such amounts will be appropriated.

''(2) ALTERNATE BUDGETS.—

''(A) IN GENERAL.—With respect to a fiscal year, the Director of the Institute shall prepare and submit to the Secretary and the Director of the National Institutes of Health the budget estimates described in subparagraph (B) for carrying out the plan for the fiscal year. The Secretary and such Director shall consider each of such estimates in making recommenda-

tions to the President regarding a budget for the plan for such year.

''(B) DESCRIPTION.—With respect to the fiscal year involved, the budget estimates referred to in subparagraph (A) for the plan are as follows:

''(i) The budget estimate submitted under paragraph (1).

''(ii) A budget estimate developed on the assumption that the amounts appropriated will be sufficient only for—

''(I) continuing the conduct by the institutes and centers of the National Institutes of Health of existing minority health and health disparity activities (if approved for continuation), and continuing the support of such activities by the institutes and centers in the case of projects or programs for which the institutes or centers have made a commitment of continued support; and

''(II) carrying out activities that are in addition to activities specified in subclause (I), only for which the

Director determines there is the most substantial need.

''(iii) Such other budget estimates as the Director of the Institute determines to be appropriate.''.

SEC. 414. IOM REPORT ON LGBT HEALTH DISPARITIES.

The Secretary of Health and Human Services shall enter into an agreement with the Institute of Medicine to prepare and submit to the Congress a report on—

(1) health and health care disparities experienced by the lesbian, gay, bisexual, and transgender communities; and

(2) the unique health and health care challenges experienced by such communities.

Subtitle B—Improving Environmental Justice

SEC. 421. CODIFICATION OF EXECUTIVE ORDER 12898.

(a) IN GENERAL.—The President of the United States is authorized and directed to execute, administer, and enforce as a matter of Federal law the provisions of Executive Order 12898, dated February 11, 1994 (''Federal Actions To Address Environmental Justice In Minority Populations and Low-Income Populations''), with such modifications as are provided in this section.

(b) DEFINITION OF ENVIRONMENTAL JUSTICE.—For purposes of carrying out the provisions of Executive Order 12898, the following definitions shall apply:

(1) The term ''environmental justice'' means the fair treatment and meaningful involvement of all people regardless of race, color, national origin, educational level, or income with respect to the development, implementation, and enforcement of environmental laws and regulations in order to ensure that—

(A) minority and low-income communities have access to public information relating to human health and environmental planning, regulations, and enforcement; and

(B) no minority or low-income population is forced to shoulder a disproportionate burden of the negative human health and environmental impacts of pollution or other environmental hazard.

(2) The term ''fair treatment'' means policies and practices that ensure that no group of people, including racial, ethnic, or socioeconomic groups bear disproportionately high and adverse human health or environmental effects resulting from Federal agency programs, policies, and activities.

(c) JUDICIAL REVIEW AND RIGHTS OF ACTION.—The provisions of section 6–609 of Executive Order 12898 shall not apply for purposes of this Act.

SEC. 422. IMPLEMENTATION OF RECOMMENDATIONS BY ENVIRONMENTAL PROTECTION AGENCY.

(a) INSPECTOR GENERAL RECOMMENDATIONS.—The Administrator of the Environmental Protection Agency shall, as promptly as practicable, carry out each of the following recommendations of the Inspector General of the agency as set forth in Report No. 2006–P–00034 entitled ''EPA needs to conduct environmental justice reviews of its programs, policies and activities'':

(1) The recommendation that the Agency's program and regional offices identify which programs, policies, and activities need environmental justice reviews and require these offices to establish a plan to complete the necessary reviews.

(2) The recommendation that the Administrator of the Agency ensure that these reviews determine whether the programs, policies, and activities may have a disproportionately high and adverse health or environmental impact on minority and low-income populations.

(3) The recommendation that each program and regional office develop specific environmental

justice review guidance for conducting environmental justice reviews.

(4) The recommendation that the Administrator designate a responsible office to compile results of environmental justice reviews and recommend appropriate actions.

(b) GAO RECOMMENDATIONS.—In developing rules under laws administered by the Environmental Protection Agency, the Administrator of the Agency shall, as promptly as practicable, carry out each of the following recommendations of the Comptroller General of the United States as set forth in GAO Report numbered GAO–05–289 entitled ''EPA Should Devote More Attention to Environmental Justice when Developing Clean Air Rules'':

(1) The recommendation that the Administrator ensure that workgroups involved in developing a rule devote attention to environmental justice while drafting and finalizing the rule.

(2) The recommendation that the Administrator enhance the ability of such workgroups to identify potential environmental justice issues through such steps as providing workgroup members with guidance and training to helping them identify potential environmental justice problems and involving envi-

ronmental justice coordinators in the workgroups when appropriate.

(3) The recommendation that the Administrator improve assessments of potential environmental justice impacts in economic reviews by identifying the data and developing the modeling techniques needed to assess such impacts.

(4) The recommendation that the Administrator direct appropriate Agency officers and employees to respond fully when feasible to public comments on environmental justice, including improving the Agency's explanation of the basis for its conclusions, together with supporting data.

(c) 2004 INSPECTOR GENERAL REPORT.—The Administrator of the Environmental Protection Agency shall, as promptly as practicable, carry out each of the following recommendations of the Inspector General of the Agency as set forth in the report entitled ''EPA Needs to Consistently Implement the Intent of the Executive Order on Environmental Justice'' (Report No. 2004–P–00007):

(1) The recommendation that the Agency clearly define the mission of the Office of Environmental Justice (OEJ) and provide Agency staff with an understanding of the roles and responsibilities of the Office.

(2) The recommendation that the Agency establish (through issuing guidance or a policy statement from the Administrator) specific time frames for the development of definitions, goals, and measurements regarding environmental justice and provide the regions and program offices a standard and consistent definition for a minority and low-income community, with instructions on how the Agency will implement and operationalize environmental justice into the Agency's daily activities.

(3) The recommendation that the Agency ensure the comprehensive training program currently under development includes standard and consistent definitions of the key environmental justice concepts (such as ''low-income'', ''minority'', and ''disproportionately impacted'') and instructions for implementation of those concepts.

(d) REPORT.—The Administrator shall submit an initial report to Congress within 6 months after the enactment of this Act regarding the Administrator's strategy for implementing the recommendations referred to in subsections (a), (b), and (c). Thereafter, the Administrator shall provide semi-annual reports to Congress regarding the Administrator's progress in implementing such recommendations and modifying the Administrator's emer-

gency management procedures to incorporate environmental justice in the Agency's Incident Command Structure (in accordance with the December 18, 2006, letter from the Deputy Administrator to the Acting Inspector General of the agency).

SEC. 423. GRANT PROGRAM.

(a) DEFINITIONS.—In this section:

(1) DIRECTOR.—The term ''Director'' means the Director of the Centers for Disease Control and Prevention, acting in collaboration with the Administrator of the Environmental Protection Agency and the Director of the National Institute of Environmental Health Sciences.

(2) ELIGIBLE ENTITY.—The term ''eligible entity'' means a State or local community that—

(A) bears a disproportionate burden of exposure to environmental health hazards;

(B) has established a coalition—

(i) with not less than 1 community-based organization; and

(ii) with not less than 1—

(I) public health entity;

(II) health care provider organization; or

(III) academic institution, including any minority-serving institution (including an Hispanic-serving institution, a historically Black college or university, and a tribal college or university);

(C) ensures planned activities and funding streams are coordinated to improve community health; and

(D) submits an application in accordance with subsection (c).

(b) ESTABLISHMENT.—The Director shall establish a grant program under which eligible entities shall receive grants to conduct environmental health improvement activities.

(c) APPLICATION.—To receive a grant under this section, an eligible entity shall submit an application to the Director at such time, in such manner, and accompanied by such information as the Director may require.

(d) COOPERATIVE AGREEMENTS.—An eligible entity may use a grant under this section—

(1) to promote environmental health; and

(2) to address environmental health disparities.

(e) AMOUNT OF COOPERATIVE AGREEMENT.—

(1) IN GENERAL.—The Director shall award grants to eligible entities at the 2 different funding levels described in this subsection.

(2) LEVEL 1 COOPERATIVE AGREEMENTS.—

(A) IN GENERAL.—An eligible entity awarded a grant under this paragraph shall use the funds to identify environmental health problems and solutions by—

(i) establishing a planning and prioritizing council in accordance with subparagraph (B); and

(ii) conducting an environmental health assessment in accordance with subparagraph (C).

(B) PLANNING AND PRIORITIZING COUNCIL.—

(i) IN GENERAL.—A prioritizing and planning council established under subparagraph (A)(i) (referred to in this paragraph as a ''PPC'') shall assist the environmental health assessment process and environmental health promotion activities of the eligible entity.

(ii) MEMBERSHIP.—Membership of a PPC shall consist of representatives from

various organizations within public health, planning, development, and environmental services and shall include stakeholders from vulnerable groups such as children, the elderly, disabled, and minority ethnic groups that are often not actively involved in democratic or decision-making processes.

(iii) DUTIES.—A PPC shall—

(I) identify key stakeholders and engage and coordinate potential partners in the planning process;

(II) establish a formal advisory group to plan for the establishment of services;

(III) conduct an in-depth review of the nature and extent of the need for an environmental health assessment, including a local epidemiological profile, an evaluation of the service provider capacity of the community, and a profile of any target populations; and

(IV) define the components of care and form essential programmatic

linkages with related providers in the community.

(C) ENVIRONMENTAL HEALTH ASSESSMENT.—

(i) IN GENERAL.—A PPC shall carry out an environmental health assessment to identify environmental health concerns.

(ii) ASSESSMENT PROCESS.—The PPC shall—

(I) define the goals of the assessment;

(II) generate the environmental health issue list;

(III) analyze issues with a systems framework;

(IV) develop appropriate community environmental health indicators;

(V) rank the environmental health issues;

(VI) set priorities for action;

(VII) develop an action plan;

(VIII) implement the plan; and

(IX) evaluate progress and planning for the future.

(D) EVALUATION.—Each eligible entity that receives a grant under this paragraph shall evaluate, report, and disseminate program findings and outcomes.

(E) TECHNICAL ASSISTANCE.—The Director may provide such technical and other non-financial assistance to eligible entities as the Director determines to be necessary.

(3) LEVEL 2 COOPERATIVE AGREEMENTS.—

(A) ELIGIBILITY.—

(i) IN GENERAL.—The Director shall award grants under this paragraph to eligible entities that have already—

(I) established broad-based collaborative partnerships; and

(II) completed environmental assessments.

(ii) NO LEVEL 1 REQUIREMENT.—To be eligible to receive a grant under this paragraph, an eligible entity is not required to have successfully completed a Level 1 Cooperative Agreement (as described in paragraph (2).

(B) USE OF GRANT FUNDS.—An eligible entity awarded a grant under this paragraph

shall use the funds to further activities to carry out environmental health improvement activities, including—

(i) addressing community environmental health priorities in accordance with paragraph (2)(C)(ii), including—

(I) air quality;

(II) water quality;

(III) solid waste;

(IV) land use;

(V) housing;

(VI) food safety;

(VII) crime;

(VIII) injuries; and

(IX) healthcare services;

(ii) building partnerships between planning, public health, and other sectors, to address how the built environment impacts food availability and access and physical activity to promote healthy behaviors and lifestyles and reduce overweight and obesity, asthma, respiratory conditions, dental, oral and mental health conditions, and related co-morbidities;

(iii) establishing programs to address—

(I) how environmental and social conditions of work and living choices influence physical activity and dietary intake; or

(II) how those conditions influence the concerns and needs of people who have impaired mobility and use assistance devices, including wheelchairs and lower limb prostheses; and

(iv) convening intervention programs that examine the role of the social environment in connection with the physical and chemical environment in—

(I) determining access to nutritional food; and

(II) improving physical activity to reduce morbidity and increase quality of life.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section—

(1) $25,000,000 for fiscal year 2010; and

(2) such sums as may be necessary for fiscal years 2011 through 2014.

SEC. 424. ADDITIONAL RESEARCH ON THE RELATIONSHIP BETWEEN THE BUILT ENVIRONMENT AND THE HEALTH OF COMMUNITY RESIDENTS.

(a) DEFINITION OF ELIGIBLE INSTITUTION.—In this section, the term ''eligible institution'' means a public or private nonprofit institution that submits to the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') and the Administrator of the Environmental Protection Agency (in this section referred to as the ''Administrator'') an application for a grant under the grant program authorized under subsection (b)(2) at such time, in such manner, and containing such agreements, assurances, and information as the Secretary and Administrator may require.

(b) RESEARCH GRANT PROGRAM.—

(1) DEFINITION OF HEALTH.—In this section, the term ''health'' includes—

(A) levels of physical activity;

(B) consumption of nutritional foods;

(C) rates of crime;

(D) air, water, and soil quality;

(E) risk of injury;

(F) accessibility to healthcare services; and

(G) other indicators as determined appropriate by the Secretary.

(2) GRANTS.—The Secretary, in collaboration with the Administrator, shall provide grants to eligible institutions to conduct and coordinate research on the built environment and its influence on individual and population-based health.

(3) RESEARCH.—The Secretary shall support research that—

(A) investigates and defines the causal links between all aspects of the built environment and the health of residents;

(B) examines—

(i) the extent of the impact of the built environment (including the various characteristics of the built environment) on the health of residents;

(ii) the variance in the health of residents by—

(I) location (such as inner cities, inner suburbs, and outer suburbs); and

(II) population subgroup (such as children, the elderly, the disadvantaged); or

(iii) the importance of the built environment to the total health of residents, which is the primary variable of interest from a public health perspective;

(C) is used to develop—

(i) measures to address health and the connection of health to the built environment; and

(ii) efforts to link the measures to travel and health databases; and

(D) distinguishes carefully between personal attitudes and choices and external influences on observed behavior to determine how much an observed association between the built environment and the health of residents, versus the lifestyle preferences of the people that choose to live in the neighborhood, reflects the physical characteristics of the neighborhood; and

(E)(i) identifies or develops effective intervention strategies to promote better health among residents with a focus on behavioral interventions and enhancements of the built environment that promote increased use by residents; and

(ii) in developing the intervention strategies under clause (i), ensures that the intervention strategies will reach out to high-risk populations, including racial and ethnic minorities and low-income urban and rural communities.

(4) PRIORITY.—In providing assistance under the grant program authorized under paragraph (2), the Secretary and the Administrator shall give priority to research that incorporates—

(A) minority-serving institutions as grantees;

(B) interdisciplinary approaches; or

(C) the expertise of the public health, physical activity, urban planning, and transportation research communities in the United States and abroad.

TITLE V—IMPROVEMENT OF HEALTH CARE SERVICES

Subtitle A—Health Empowerment Zones

SEC. 501. SHORT TITLE.

This subtitle may be cited as the ''Health Empowerment Zone Act of 2009''.

SEC. 502. FINDINGS.

The Congress finds the following:

(1) Numerous studies and reports, including the National Healthcare Disparities Report and Unequal Treatment, the 2002 Institute of Medicine Report, document the extensiveness to which health disparities exist across the country.

(2) These studies have found that, on average, racial and ethnic minorities are disproportionately afflicted with chronic and acute conditions—such as cancer, diabetes, and hypertension—and suffer worse health outcomes, worse health status, and higher mortality rates than their White counterparts.

(3) Several recent studies also show that health disparities are a function of not only access to health care, but also the social determinants of health—including the environment, the physical structure of communities, nutrition and food options, educational attainment, employment, race, ethnicity, geography, and language preference—that directly and indirectly affect the health, health care, and wellness of individuals and communities.

(4) Integrally involving and fully supporting the communities most affected by health inequities in the assessment, planning, launch, and evaluation of health disparity elimination efforts is among the

leading recommendations made to adequately address and ultimately reduce health disparities.

(5) Recommendations also include supporting the efforts of community stakeholders from a broad cross-section—including, but not limited to local businesses, local departments of commerce, education, labor, urban planning, and transportation, and community-based and other nonprofit organizations—to find areas of common ground around health disparity elimination and collaborate to improve the overall health and wellness of a community and its residents.

SEC. 503. DESIGNATION OF HEALTH EMPOWERMENT ZONES.

(a) IN GENERAL.—At the request of an eligible community partnership, the Secretary may designate an eligible area as a health empowerment zone.

(b) ELIGIBILITY CRITERIA.—

(1) ELIGIBLE COMMUNITY PARTNERSHIP.—A community partnership is eligible to submit a request under this section if the partnership—

(A) demonstrates widespread public support from key individuals and entities in the eligible area, including State and local governments, nonprofit organizations, and community

and industry leaders, for designation of the eligible area as a health empowerment zone; and

(B) includes representatives of—

(i) a broad cross section of stakeholders and residents from communities in the eligible area experiencing disproportionate disparities in health status and health care; and

(ii) organizations, facilities, and institutions that have a history of working within and serving such communities.

(2) ELIGIBLE AREA.—An area is eligible to be designated as a health empowerment zone under this section if one or more communities in the area experience disproportionate disparities in health status and health care. In determining whether a community experiences such disparities, the Secretary shall consider the data collected by the Department of Health and Human Services focusing on the following areas:

(A) Access to high-quality health services.

(B) Arthritis, osteoporosis, and chronic back conditions.

(C) Cancer.

(D) Chronic kidney disease.

(E) Diabetes.

(F) Injury and violence prevention.

(G) Maternal, infant, and child health.

(H) Medical product safety.

(I) Mental health and mental disorders.

(J) Nutrition and overweight.

(K) Disability and secondary conditions.

(L) Educational and community-based health programs.

(M) Environmental health.

(N) Family planning.

(O) Food safety.

(P) Health communication.

(Q) Health disease and stroke.

(R) HIV/AIDS.

(S) Immunization and infectious diseases.

(T) Occupational safety and health.

(U) Oral health.

(V) Physical activity and fitness.

(W) Public health infrastructure.

(X) Respiratory diseases.

(Y) Sexually transmitted diseases.

(Z) Substance abuse.

(AA) Tobacco use.

(BB) Vision and hearing.

(c) PROCEDURE.—

(1) REQUEST.—A request under subsection (a) shall—

(A) describe the bounds of the area to be designated as a health empowerment zone and the process used to select those bounds;

(B) demonstrate that the partnership submitting the request is an eligible community partnership described in subsection (b)(1);

(C) demonstrate that the area is an eligible area described in subsection (b)(2);

(D) include a comprehensive assessment of disparities in health status and health care experience by one or more communities in the area;

(E) set forth—

(i) a vision and a set of values for the area; and

(ii) a comprehensive and holistic set of goals to be achieved in the area through designation as a health empowerment zone; and

(F) include a strategic plan for achieving the goals described in subparagraph (E)(ii).

(2) APPROVAL.—Not later than 60 days after the receipt of a request for designation of an area as a health empowerment zone under this section, the Secretary shall approve or disapprove the request.

(d) MINIMUM NUMBER.—The Secretary—

(1) shall designate not more than 110 health empowerment zones under this section; and

(2) shall designate at least one health empowerment zone in each of the several States, the District of Columbia, and each territory or possession of the United States.

SEC. 504. ASSISTANCE TO THOSE SEEKING DESIGNATION.

At the request of any organization or entity seeking to submit a request under section 503(a), the Secretary shall provide technical assistance, and may award a grant, to assist such organization or entity—

(1) to form an eligible community partnership described in section 503(b)(1);

(2) to complete a health assessment, including an assessment of health disparities under section 503(c)(1)(D); or

(3) to prepare and submit a request, including a strategic plan, in accordance with section 503.

SEC. 505. BENEFITS OF DESIGNATION.

(a) PRIORITY.—In awarding any competitive grant, a Federal official shall give priority to any applicant that—

(1) meets the eligibility criteria for the grant;

(2) proposes to use the grant for activities in a health empowerment zone; and

(3) demonstrates that such activities will directly and significantly further the goals of the strategic plan approved for such zone under section 503.

(b) GRANTS FOR INITIAL IMPLEMENTATION OF STRATEGIC PLAN.—

(1) IN GENERAL.—Upon designating an eligible area as a health empowerment zone at the request of an eligible community partnership, the Secretary shall, subject to the availability of appropriations, make a grant to the community partnership for implementation of the strategic plan for such zone.

(2) GRANT PERIOD.—A grant under paragraph (1) for a health empowerment zone shall be for a period of 2 years and may be renewed, except that the total period of grants under paragraph (1) for such zone may not exceed 10 years.

(3) LIMITATION.—In awarding grants under this subsection, the Secretary shall not give less priority to an applicant or reduce the amount of a

grant because the Secretary rendered technical assistance or made a grant to the same applicant under section 504.

(4) REPORTING.—The Secretary shall require each recipient of a grant under this subsection to report to the Secretary not less than every 6 months on the progress in implementing the strategic plan for the health empowerment zone.

SEC. 506. DEFINITION.

In this subtitle, the term ''Secretary'' means the Secretary of Health and Human Services, acting through the Administrator of the Health Resources and Services Administration and the Director of the Office of Minority Health, and in cooperation with the Director of the Office of Community Services and the Director of the National Institute for Minority Health and Health Disparities.

SEC. 507. AUTHORIZATION OF APPROPRIATIONS.

To carry out this subtitle, there is authorized to be appropriated $100,000,000 for fiscal year 2010.

Subtitle B—Other Improvements of Health Care Services

CHAPTER 1—IN GENERAL

SEC. 511. AMENDMENT TO THE PUBLIC HEALTH SERVICE ACT.

Title XXXI of the Public Health Service Act, as amended by titles II, III, and IV of this Act, is further amended by adding at the end the following:

"Subtitle D—Reconstruction and Improvement Grants for Public Health Care Facilities Serving Pacific Islanders and the Insular Areas

"SEC. 3151. GRANT SUPPORT FOR QUALITY IMPROVEMENT INITIATIVES.

''(a) IN GENERAL.—The Secretary, in collaboration with the Administrator of the Health Resources and Services Administration, the Director of the Agency for Healthcare Research and Quality, and the Administrator of the Centers for Medicare & Medicaid Services, shall award grants to eligible entities for the conduct of demonstration projects to improve the quality of and access to health care.

''(b) ELIGIBILITY.—To be eligible to receive a grant under subsection (a), an entity shall—

''(1) be a health center, hospital, health plan, health system, community clinic. or other health entity determined appropriate by the Secretary—

''(A) that, by legal mandate or explicitly adopted mission, provides patients with access to services regardless of their ability to pay;

''(B) that provides care or treatment for a substantial number of patients who are uninsured, are receiving assistance under a State program under title XIX of the Social Security Act, or are members of vulnerable populations, as determined by the Secretary; and

''(C)(i) with respect to which, not less than 50 percent of the entity's patient population is made up of racial and ethnic minorities; or

''(ii) that—

''(I) serves a disproportionate percentage of local, minority racial and ethnic patients, or that has a patient population, at least 50 percent of which is limited English proficient; and

''(II) provides an assurance that amounts received under the grant will be used only to support quality improvement

activities in the racial and ethnic population served; and

''(2) prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

''(c) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to applicants under subsection (b)(2) that—

''(1) demonstrate an intent to operate as part of a health care partnership, network, collaborative, coalition, or alliance where each member entity contributes to the design, implementation, and evaluation of the proposed intervention; or

''(2) intend to use funds to carry out system-wide changes with respect to health care quality improvement, including—

''(A) improved systems for data collection and reporting;

''(B) innovative collaborative or similar processes;

''(C) group programs with behavioral or self-management interventions;

''(D) case management services;

''(E) physician or patient reminder systems;

''(F) educational interventions; or

''(G) other activities determined appropriate by the Secretary.

''(d) USE OF FUNDS.—An entity shall use amounts received under a grant under subsection (a) to support the implementation and evaluation of health care quality improvement activities or minority health and health care disparity reduction activities that include—

''(1) with respect to health care systems, activities relating to improving—

''(A) patient safety;

''(B) timeliness of care;

''(C) effectiveness of care;

''(D) efficiency of care;

''(E) patient centeredness; and

''(F) health information technology; and

''(2) with respect to patients, activities relating to—

''(A) staying healthy;

''(B) getting well;

''(C) living with illness or disability; and

''(D) coping with end of life issues.

''(e) COMMON DATA SYSTEMS.—The Secretary shall provide financial and other technical assistance to grantees under this section for the development of common data systems.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

''SEC. 3152. CENTERS OF EXCELLENCE.

''(a) IN GENERAL.—The Secretary, acting through the Administrator of the Health Resources and Services Administration, shall designate centers of excellence at public hospitals, and other health systems serving large numbers of minority patients, that—

''(1) meet the requirements of section 3151(b)(1);

''(2) demonstrate excellence in providing care to minority populations; and

''(3) demonstrate excellence in reducing disparities in health and health care.

''(b) REQUIREMENTS.—A hospital or health system that serves as a Center of Excellence under subsection (a) shall—

''(1) design, implement, and evaluate programs and policies relating to the delivery of care in ra-

cially, ethnically, and linguistically diverse populations;

''(2) provide training and technical assistance to other hospitals and health systems relating to the provision of quality health care to minority populations; and

''(3) develop activities for graduate or continuing medical education that institutionalize a focus on cultural competence training for health care providers.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2010 through 2015.

''SEC. 3153. RECONSTRUCTION AND IMPROVEMENT GRANTS FOR PUBLIC HEALTH CARE FACILITIES SERVING PACIFIC ISLANDERS AND THE INSULAR AREAS.

''(a) IN GENERAL.—The Secretary shall provide direct financial assistance to designated health care providers and community health centers in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii for the purposes of reconstructing and improving health care facilities and services.

''(b) ELIGIBILITY.—To be eligible to receive direct financial assistance under subsection (a), an entity shall be a public health facility or community health center located in American Samoa, Guam, or the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii that—

''(1) is owned or operated by—

''(A) the government of American Samoa, Guam, or the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii or a unit of local government; or

''(B) a nonprofit organization; and

''(2)(A) provides care or treatment for a substantial number of patients who are uninsured, receiving assistance under a State program under a title XVIII of the Social Security Act, or a State program under title XIX of such Act, or who are members of a vulnerable population, as determined by the Secretary; or

''(B) serves a disproportionate percentage of local, minority racial and ethnic patients.

''(c) REPORT.—Not later than 180 days after the date of enactment of this title and annually thereafter, the Secretary shall submit to the Congress and the President

a report that includes an assessment of health resources and facilities serving populations in American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii. In preparing such report, the Secretary shall—

''(1) consult with and obtain information on all health care facilities needs from the entities described in subsection (b);

''(2) include all amounts of Federal assistance received by each entity in the preceding fiscal year;

''(3) review the total unmet needs of each jurisdiction for health care facilities, including needs for renovation and expansion of existing facilities; and

''(4) include a strategic plan for addressing the needs of each jurisdiction identified in the report.

''(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as necessary to carry out this section.''.

SEC. 512. MEDICAID PAYMENT FOR CERTAIN ALIENS.

(a) MEDICAID.—Section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)) is amended by striking paragraph (4) and inserting the following:

''(4)(A) Notwithstanding sections 401(a), 402(b), 403, and 421 of Public Law 104–193, payment shall be

made under this section for care and services that are furnished to individuals, if they who otherwise meet the eligibility requirements for medical assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment), and are—

''(i) lawfully present in the United States;

''(ii) children under age 21, including optional targeted low-income children described in section 1905(u)(2)(B); or

''(iii) pregnant women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

''(B) No debt shall accrue under an affidavit of support against any sponsor of such individual on the basis of provision of medical assistance and the cost of such assistance shall not be considered as an unreimbursed cost.''.

(b) SCHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended by striking subparagraph (H) and inserting the following:

''(H) Paragraph (4) of section 1903(v) (relating to individuals who, but for sections 401(a), 403, and 421 of Public Law 104–193

would be eligible for medical assistance under title XXI).''.

(c) CONFORMING AMENDMENT.—Section 1137(f) of such Act (42 U.S.C. 1320b–7(f)) is amended by inserting ''and for medical assistance provided to children and pregnant women'' before the period at the end.

SEC. 513. MEDICAID PAYMENT PARITY FOR THE TERRITORIES.

(a) ELIMINATION OF FUNDING LIMITATIONS FOR PUERTO RICO, THE VIRGIN ISLANDS, GUAM, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA.—

(1) IN GENERAL.—Section 1108 of the Social Security Act (42 U.S.C. 1308) is amended—

(A) in subsection (f), in the matter before paragraph (1), by striking ''subsection (g)'' and inserting ''subsections (g) and (h)'';

(B) in subsection (g)(2), in the matter before subparagraph (A), by inserting ''and subsection (h)'' after ''paragraph (3)''; and

(C) by adding at the end the following new subsection:

''(h) SUNSET OF FUNDING LIMITATIONS FOR PUERTO RICO, THE VIRGIN ISLANDS, GUAM, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA.—Subsections (f) and (g) shall not apply to Puerto Rico, the Virgin Is-

lands, Guam, the Northern Mariana Islands, and American Samoa for any fiscal year after fiscal year 2009.''.

(2) CONFORMING AMENDMENT.—Section 1903(u) of such Act (42 U.S.C. 1396c(u)) is amended by striking paragraph (4).

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply beginning with fiscal year 2010.

(b) PARITY IN FMAP.—

(1) IN GENERAL.—Section 1905(b)(2) of such Act (42 U.S.C. 1396d(b)(2)) is amended by inserting after ''50 per centum'' the following: ''(except that, beginning with fiscal year 2012, the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be the Federal medical assistance percentage determined by the Secretary in consultation (for the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa) with the Secretary of the Interior)''.

(2) 2-FISCAL-YEAR TRANSITION.—Notwithstanding any other provision of law, during fiscal years 2010 and 2011, the Federal medical assistance percentage established under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) for

Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be the highest such Federal medical assistance percentage applicable to any of the 50 States or the District of Columbia for the fiscal year involved, taking into account the application of subsections (a) and (b)(1) of 5001 of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) to such States and District for calendar quarters during such fiscal years for which such subsections apply respectively.

(3) PER CAPITA INCOME DATA.—

(A) REPORT TO CONGRESS.—Not later than October 1, 2010, the Secretary of Health and Human Services shall submit to Congress a report that describes the per capita income data used to promulgate the Federal medical assistance percentage in the territories and how such data differ from the per capita income data used to promulgate Federal medical assistance percentages for the 50 States and the District of Columbia. The report should include recommendations on how the Federal medical assistance percentages can be calculated for the

territories to ensure parity with the 50 States and the District of Columbia.

(B) APPLICATION.—Section 1101(a)(8)(B) of the Social Security Act (42 U.S.C. 1308(a)(8)(B)) is amended—

(i) by striking ''(other than Puerto Rico, the Virgin Islands, and Guam)'' and inserting ''(including Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa)''; and

(ii) by inserting ''(or, if such satisfactory data are not available in the case of the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa, satisfactory data available from the Department of the Interior for the same period, or if such satisfactory data are not available in the case of Puerto Rico, satisfactory data available from the government of the Commonwealth of Puerto Rico for the same period)'' after ''Department of Commerce''.

(4) RELATION TO AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009.—For any period and territory in which the provisions of this subsection

apply to a territory, the provisions of section 5001(b)(2) of division B of the American Recovery and Reinvestment Act of 2009 (Public Law 111–5) shall not apply (except as otherwise specifically provided in paragraph (2)).

SEC. 514. EXTENSION OF MEDICARE SECONDARY PAYER.

(a) IN GENERAL.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence, by inserting ", and before January 1, 2010" after "prior to such date)"; and

(2) by adding at the end the following new sentence: "Effective for items and services furnished on or after January 1, 2010 (with respect to periods beginning on or after the date that is 42 months prior to such date), clauses (i) and (ii) shall be applied by substituting '42-month' for '12-month' each place it appears in the first sentence.".

(b) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of enactment of this Act. For purposes of determining an individual's status under section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)), as amended by paragraph (1), an individual who is within the coordinating

period as of the date of enactment of this Act shall have that period extended to the full 42 months described in the last sentence of such section, as added by the amendment made by paragraph (1)(B).

SEC. 515. BORDER HEALTH GRANTS.

(a) ELIGIBLE ENTITY DEFINED.—In this section, the term ''eligible entity'' means a State, public institution of higher education, local government, tribal government, nonprofit health organization, community health center, or community clinic receiving assistance under section 330 of the Public Health Service Act (42 U.S.C. 254b), that is located in the border area.

(b) AUTHORIZATION.—From funds appropriated under subsection (f), the Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the United States members of the United States-Mexico Border Health Commission, shall award grants to eligible entities to address priorities and recommendations to improve the health of border area residents that are established by—

(1) the United States members of the United States-Mexico Border Health Commission;

(2) the State border health offices; and

(3) the Secretary.

(c) APPLICATION.—An eligible entity that desires a grant under subsection (b) shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(d) USE OF FUNDS.—An eligible entity that receives a grant under subsection (b) shall use the grant funds for—

(1) programs relating to—

(A) maternal and child health;

(B) primary care and preventative health;

(C) public health and public health infrastructure;

(D) health education and promotion;

(E) oral health;

(F) mental and behavioral health;

(G) substance abuse;

(H) health conditions that have a high prevalence in the border area;

(I) medical and health services research;

(J) workforce training and development;

(K) community health workers or promotoras;

(L) health care infrastructure problems in the border area (including planning and construction grants);

(M) health disparities in the border area;

(N) environmental health; and

(O) outreach and enrollment services with respect to Federal programs (including programs authorized under titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 and 1397aa)); and

(2) other programs determined appropriate by the Secretary.

(e) SUPPLEMENT, NOT SUPPLANT.—Amounts provided to an eligible entity awarded a grant under subsection (b) shall be used to supplement and not supplant other funds available to the eligible entity to carry out the activities described in subsection (d).

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $200,000,000 for fiscal year 2010, and such sums as may be necessary for each succeeding fiscal year.

SEC. 516. CANCER PREVENTION AND TREATMENT DEMONSTRATION FOR ETHNIC AND RACIAL MINORITIES.

(a) DEMONSTRATION.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct demonstration projects

(in this section referred to as ''demonstration projects'') for the purpose of developing models and evaluating methods that—

(A) improve the quality of items and services provided to target individuals in order to facilitate reduced disparities in early detection and treatment of cancer;

(B) improve clinical outcomes, satisfaction, quality of life, and appropriate use of Medicare-covered services and referral patterns among those target individuals with cancer;

(C) eliminate disparities in the rate of preventive cancer screening measures, such as pap smears, prostate cancer screenings, and CT scans for lung cancer among target individuals; and

(D) promote collaboration with community-based organizations to ensure cultural competency of health care professionals and linguistic access for persons with limited English proficiency.

(2) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual of a racial and ethnic minority group, as defined by section 1707 of the Public Health Service

Act (42 U.S.C. 300u–6) who is entitled to benefits under part A, and enrolled under part B, of title XVIII of the Social Security Act.

(b) PROGRAM DESIGN.—

(1) INITIAL DESIGN.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall evaluate best practices in the private sector, community programs, and academic research of methods that reduce disparities among individuals of racial and ethnic minority groups in the prevention and treatment of cancer and shall design the demonstration projects based on such evaluation.

(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall implement at least nine demonstration projects, including the following:

(A) Two projects for each of the four following major racial and ethnic minority groups:

(i) American Indians and Alaska Natives, Eskimos and Aleuts.

(ii) Asian Americans.

(iii) Blacks/African Americans.

(iv) Hispanic/Latino Americans.

(v) Native Hawaiians and other Pacific Islanders.

The two projects must target different ethnic subpopulations.

(B) One project within the Pacific Islands or United States insular areas.

(C) At least one project each in a rural area and inner-city area.

(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—If the initial report under subsection (c) contains an evaluation that demonstration projects—

(A) reduce expenditures under the Medicare program under title XVIII of the Social Security Act; or

(B) do not increase expenditures under the Medicare program and reduce racial and ethnic health disparities in the quality of health care services provided to target individuals and increase satisfaction of beneficiaries and health care providers;

the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects.

(c) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the date the Secretary implements the initial dem-

onstration projects, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects.

(2) CONTENTS OF REPORT.—Each report under paragraph (1) shall include the following:

(A) A description of the demonstration projects.

(B) An evaluation of—

(i) the cost-effectiveness of the demonstration projects;

(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

(iii) beneficiary and health care provider satisfaction under the demonstration projects.

(C) Any other information regarding the demonstration projects that the Secretary determines to be appropriate.

(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

SEC. 517. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS IN WOMEN AND CHILDREN.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.) is amended—

(1) by redesignating the second and third sections 399R (added by Public Laws 110–373 and 110–374) as sections 399S and 399T, respectively; and

(2) by adding at the end the following:

"SEC. 399U. GRANTS TO PROMOTE POSITIVE HEALTH BEHAVIORS IN WOMEN AND CHILDREN.

''(a) GRANTS AUTHORIZED.—The Secretary, in collaboration with the Director of the Centers for Disease Control and Prevention and other Federal officials determined appropriate by the Secretary, is authorized to award grants to eligible entities to promote positive health behaviors for women and children in target populations, especially racial and ethnic minority women and children in medically underserved communities.

''(b) USE OF FUNDS.—Grants awarded pursuant to subsection (a) may be used to support community health workers—

''(1) to educate and provide outreach regarding enrollment in health insurance including the State Children's Health Insurance Program under title XXI of the Social Security Act, Medicare under title

XVIII of such Act, and Medicaid under title XIX of such Act;

''(2) to educate, guide, and provide outreach in a community setting regarding health problems prevalent among women and children and especially among racial and ethnic minority women and children;

''(3) to educate, guide, and provide experiential learning opportunities that target behavioral risk factors including—

''(A) poor nutrition;

''(B) physical inactivity;

''(C) being overweight or obese;

''(D) tobacco use;

''(E) alcohol and substance use;

''(F) injury and violence;

''(G) risky sexual behavior;

''(H) mental health problems;

''(I) dental and oral health problems; and

''(J) understanding informed consent;

''(4) to educate and guide regarding effective strategies to promote positive health behaviors within the family;

''(5) to promote community wellness and awareness; and

''(6) to educate and refer target populations to appropriate health care agencies and community-based programs and organizations in order to increase access to quality health care services, including preventive health services.

''(c) APPLICATION.—

''(1) IN GENERAL.—Each eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

''(2) CONTENTS.—Each application submitted pursuant to paragraph (1) shall—

''(A) describe the activities for which assistance under this section is sought;

''(B) contain an assurance that with respect to each community health worker program receiving funds under the grant awarded, such program provides training and supervision to community health workers to enable such workers to provide authorized program services;

''(C) contain an assurance that the applicant will evaluate the effectiveness of community health worker programs receiving funds under the grant;

"(D) contain an assurance that each community health worker program receiving funds under the grant will provide services in the cultural context most appropriate for the individuals served by the program;

"(E) contain a plan to document and disseminate project description and results to other States and organizations as identified by the Secretary; and

"(F) describe plans to enhance the capacity of individuals to utilize health services and health-related social services under Federal, State, and local programs by—

"(i) assisting individuals in establishing eligibility under the programs and in receiving the services or other benefits of the programs; and

"(ii) providing other services as the Secretary determines to be appropriate, that may include transportation and translation services.

"(d) PRIORITY.—In awarding grants under subsection (a), the Secretary shall give priority to those applicants—

"(1) who propose to target geographic areas—

''(A) with a high percentage of residents who are eligible for health insurance but are uninsured or underinsured; and

''(B) with a high percentage of families for whom English is not their primary language.

''(2) with experience in providing health or health-related social services to individuals who are underserved with respect to such services; and

''(3) with documented community activity and experience with community health workers.

''(e) COLLABORATION WITH ACADEMIC INSTITUTIONS.—The Secretary shall encourage community health worker programs receiving funds under this section to collaborate with academic institutions, including minority-serving institutions. Nothing in this section shall be construed to require such collaboration.

''(f) QUALITY ASSURANCE AND COST-EFFECTIVENESS.—The Secretary shall establish guidelines for assuring the quality of the training and supervision of community health workers under the programs funded under this section and for assuring the cost-effectiveness of such programs.

''(g) MONITORING.—The Secretary shall monitor community health worker programs identified in approved applications and shall determine whether such programs

are in compliance with the guidelines established under subsection (f).

''(h) TECHNICAL ASSISTANCE.—The Secretary may provide technical assistance to community health worker programs identified in approved applications with respect to planning, developing, and operating programs under the grant.

''(i) REPORT TO CONGRESS.—

''(1) IN GENERAL.—Not later than 4 years after the date on which the Secretary first awards grants under subsection (a), the Secretary shall submit to Congress a report regarding the grant project.

''(2) CONTENTS.—The report required under paragraph (1) shall include the following:

''(A) A description of the programs for which grant funds were used.

''(B) The number of individuals served.

''(C) An evaluation of—

''(i) the effectiveness of these programs;

''(ii) the cost of these programs; and

''(iii) the impact of the project on the health outcomes of the community residents.

''(D) Recommendations for sustaining the community health worker programs developed or assisted under this section.

''(E) Recommendations regarding training to enhance career opportunities for community health workers.

''(j) DEFINITIONS.—In this section:

''(1) COMMUNITY HEALTH WORKER.—The term 'community health worker' means an individual who promotes health or nutrition within the community in which the individual resides—

''(A) by serving as a liaison between communities and health care agencies;

''(B) by providing guidance and social assistance to community residents;

''(C) by enhancing community residents' ability to effectively communicate with health care providers;

''(D) by providing culturally and linguistically appropriate health or nutrition education;

''(E) by advocating for individual and community health, including dental, oral, mental, and environmental health, or nutrition needs; and

"(F) by providing referral and followup services.

"(2) COMMUNITY SETTING.—The term 'community setting' means a home or a community organization located in the neighborhood in which a participant resides.

"(3) ELIGIBLE ENTITY.—The term 'eligible entity' means—

"(A) a unit of State, territorial, local, or tribal government (including a federally recognized tribe or Alaska native villages); or

"(B) a community-based organization.

"(4) MEDICALLY UNDERSERVED COMMUNITY.—The term 'medically underserved community' means a community—

"(A) that has a substantial number of individuals who are members of a medically underserved population, as defined by section 330(b)(3); and

"(B) a significant portion of which is a health professional shortage area as designated under section 332.

"(5) SUPPORT.—The term 'support' means the provision of training, supervision, and materials needed to effectively deliver the services described in

subsection (b), reimbursement for services, and other benefits.

''(6) TARGET POPULATION.—The term 'target population' means women of reproductive age, regardless of their current childbearing status and children under 21 years of age.

''(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $15,000,000 for each of fiscal years 2010, 2011, 2012, 2013, and 2014.''.

SEC. 518. EXCEPTION FOR CITIZENS OF FREELY ASSOCIATED STATES.

(a) IN GENERAL.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(N) EXCEPTION FOR CITIZENS OF FREELY ASSOCIATED STATES.—With respect to eligibility for benefits for the specified Federal programs described in paragraph (3), paragraph (1) shall not apply to any individual who lawfully resides in the United States (including territories and possessions of the United States) in accordance with—

"(i) section 141 of the Compact of Free Association between the Government of the United States and the Government of the Federated States of Micronesia, approved by Congress in the Compact of Free Association Amendments Act of 2003;

"(ii) section 141 of the Compact of Free Association between the Government of the United States and the Government of the Republic of the Marshall Islands, approved by Congress in the Compact of Free Association Amendments Act of 2003; or

"(iii) section 141 of the Compact of Free Association between the Government of the United States and the Government of Palau, approved by Congress in Public Law 99–658 (100 Stat. 3672).".

(b) MEDICAID EXCEPTION.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at the end the following:

"(G) MEDICAID EXCEPTIONS FOR CITIZENS OF FREELY ASSOCIATED STATES.—With

respect to eligibility for benefits for the programs defined in subparagraphs (A) and (C) of paragraph (3) (relating to Medicaid), paragraph (1) shall not apply to any individual who lawfully resides in the United States (including territories and possessions of the United States) in accordance with a Compact of Free Association referred to in subsection (a)(2)(N).''.

(c) QUALIFIED ALIEN.—Section 431(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(b)) is amended—

(1) in paragraph (6), by striking ''or'' at the end;

(2) in paragraph (7), by striking the period at the end and inserting ''; or''; and

(3) by adding at the end the following:

''(8) an individual who lawfully resides in the United States (including territories and possessions of the United States) in accordance with a Compact of Free Association referred to in section 402(a)(2)(N).''.

(d) INCREASED FMAP.—The third sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) is amended by inserting before the period at the end the following: ''and for services furnished to indi-

viduals described in section 431(b)(8) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996''.

SEC. 519. MEDICARE GRADUATE MEDICAL EDUCATION.

(a) CLARIFICATION OF CONGRESSIONAL INTENT REGARDING THE COUNTING OF RESIDENTS IN A NONHOSPITAL SETTING.—

(1) D–GME.—Section 1886(h)(4)(E) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(E)) is amended by adding at the end the following new sentences: ''For purposes of the preceding sentence, the term 'all, or substantially all, of the costs for the training program' means the stipends and benefits provided to the resident and other amounts, if any, as determined by the hospital and the entity operating the nonhospital setting. The hospital is not required to pay the entity any amounts other than those determined by the hospital and the entity in order for the hospital to be considered to have incurred all, or substantially all, of the costs for the training program in that setting.''.

(2) IME.—Section 1886(d)(5)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended by adding at the end the following new sentences: ''For purposes of the preceding sentence,

the term 'all, or substantially all, of the costs for the training program' means the stipends and benefits provided to the resident and other amounts, if any, as determined by the hospital and the entity operating the nonhospital setting. The hospital is not required to pay the entity any amounts other than those determined by the hospital and the entity in order for the hospital to be considered to have incurred all, or substantially all, of the costs for the training program in that setting.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 2010.

(b) CLARIFICATION OF ELIGIBILITY OF A NONRURAL HOSPITAL THAT HAS A TRAINING PROGRAM WITH AN INTEGRATED RURAL TRACK.—

(1) IN GENERAL.—Section 1886(h)(4)(H) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(H)) is amended—

(A) in clause (iv), by inserting ''(as defined in clause (vi))'' after ''an integrated rural track''; and

(B) by adding at the end the following new clause:

"(vi) DEFINITION OF ACCREDITED TRAINING PROGRAM WITH AN INTEGRATED RURAL TRACK.—For purposes of clause (iv), the term 'accredited training program with an integrated rural track' means an accredited medical residency training program located in an urban area which offers a curriculum for all residents in the program that includes the following characteristics:

"(I) A minimum of 3 block months of rural rotations. During such 3 block months, the resident is in a rural area for 4 weeks or a month.

"(II) A stated mission for training rural physicians.

"(III) A minimum of 3 months of obstetrical training, or an equivalent longitudinal experience.

"(IV) A minimum of 4 months of pediatric training that includes neonatal, ambulatory, inpatient, and emergency experiences through rota-

tions, or an equivalent longitudinal experience.

"(V) A minimum of 2 months of emergency medicine rotations, or an equivalent longitudinal experience.".

(2) EFFECTIVE DATE.—The amendments made by this subsection apply with respect to—

(A) payments to hospitals under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) for cost reporting periods beginning on or after January 1, 2010; and

(B) payments to hospitals under section 1886(d)(5)(B)(v) of such Act (42 U.S.C. 1395ww(d)(5)(B)(v)) for discharges occurring on or after January 1, 2010.

SEC. 520. HIV/AIDS REDUCTION IN RACIAL AND ETHNIC MINORITY COMMUNITIES.

(a) EXPANDED FUNDING.—The Secretary, in collaboration with the Director of the Office of Minority Health, the Director of the Centers for Disease Control and Prevention, the Administrator of the Health Resources and Services Administration, and the Administrator of the Substance Abuse and Mental Health Services Administration, shall provide funds and carry out activities to expand the Minority HIV/AIDS Initiative.

(b) USE OF FUNDS.—The additional funds made available under this section may be used, through the Minority AIDS Initiative, to support the following activities:

(1) Providing technical assistance and infrastructure support to reduce HIV/AIDS in minority populations.

(2) Increasing minority populations' access to HIV/AIDS prevention and care services.

(3) Building strong community programs and partnerships to address HIV prevention and the health care needs of specific racial and ethnic minority populations.

(c) PRIORITY INTERVENTIONS.—Within the racial and ethnic minority populations referred to in subsection (b), priority in conducting intervention services shall be given to—

(1) women;

(2) youth;

(3) men who engage in homosexual activity;

(4) persons who engage in intravenous drug abuse;

(5) homeless individuals; and

(6) individuals incarcerated or in the penal system.

(d) AUTHORIZATION OF APPROPRIATIONS.—For carrying out this section, there are authorized to be appropriated $610,000,0000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2014.

SEC. 521. GRANTS FOR RACIAL AND ETHNIC APPROACHES TO COMMUNITY HEALTH.

(a) PURPOSE.—It is the purpose of this section to provide for the awarding of grants to assist communities in mobilizing and organizing resources in support of effective and sustainable programs that will reduce or eliminate disparities in health and healthcare experienced by racial and ethnic minority individuals.

(b) AUTHORITY TO AWARD GRANTS.—The Secretary, acting through the Centers for Disease Control and Prevention, shall award grants to eligible entities to assist in designing, implementing, and evaluating culturally and linguistically appropriate, science-based and community-driven sustainable strategies to eliminate racial and ethnic health and healthcare disparities.

(c) ELIGIBLE ENTITIES.—To be eligible to receive a grant under this section, an entity shall—

(1) represent a coalition—

(A) whose principal purpose is to develop and implement interventions to reduce or elimi-

nate a health or healthcare disparity in a targeted racial or ethnic minority group in the community served by the coalition; and

(B) that includes—

(i) members selected from among—

(I) public health departments;

(II) community-based organizations;

(III) university and research organizations;

(IV) American Indian tribal organizations, national American Indian organizations, Indian Health Service, or organizations serving Alaska Natives; and

(V) interested public or private healthcare providers or organizations as deemed appropriate by the Secretary; and

(ii) at least 1 member from a community-based organization that represents the targeted racial or ethnic minority group; and

(2) submit to the Secretary an application at such time, in such manner, and containing such in-

formation as the Secretary may require, which shall include—

(A) a description of the targeted racial or ethnic populations in the community to be served under the grant;

(B) a description of at least 1 health disparity that exists in the racial or ethnic targeted populations, including health issues such as infant mortality, breast and cervical cancer screening and management, cardiovascular disease, diabetes, child and adult immunization levels, or other health priority area(s) as designated by the Secretary; and

(C) a demonstration of a proven record of accomplishment of the coalition members in serving and working with the targeted community.

(d) SUSTAINABILITY.—The Secretary shall give priority to an eligible entity under this section if the entity agrees that, with respect to the costs to be incurred by the entity in carrying out the activities for which the grant was awarded, the entity (and each of the participating partners in the coalition represented by the entity) will maintain its expenditures of non-Federal funds for such activities at a level that is not less than the level of such

expenditures during the fiscal year immediately preceding the first fiscal year for which the grant is awarded.

(e) NONDUPLICATION.—Funds provided through this grant program should supplement, not supplant, existing Federal funding, and the funds should not be used to duplicate the activities of the other health disparity grant programs in this Act.

(f) TECHNICAL ASSISTANCE.—The Secretary may, either directly or by grant or contract, provide any entity that receives a grant under this section with technical and other nonfinancial assistance necessary to meet the requirements of this section.

(g) DISSEMINATION.—The Secretary shall encourage and enable grantees to share best practices, evaluation results, and reports with communities not affiliated with grantees using the Internet, conferences, and other pertinent information regarding the projects funded by this section, including the outreach efforts of the Office of Minority Health and Health Disparity Elimination and the Centers for Disease Control and Prevention.

(h) ADMINISTRATIVE BURDENS.—The Secretary shall make every effort to minimize duplicative or unnecessary administrative burdens on grantees.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the Public Health Service Act.

SEC. 522. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.

(a) ELIMINATION OF ISOLATION TEST FOR COST-BASED AMBULANCE REIMBURSEMENT.—

(1) IN GENERAL.—Section 1834(l)(8) of the Social Security Act (42 U.S.C. 1395m(l)(8)) is amended—

(A) in subparagraph (B)—

(i) by striking ''owned and''; and

(ii) by inserting ''(including when such services are provided by the entity under an arrangement with the hospital)'' after ''hospital''; and

(B) by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2010.

(b) PROVISION OF A MORE FLEXIBLE ALTERNATIVE TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT REQUIREMENT.—

(1) IN GENERAL.—Section 1820(c)(2) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)) is amended—

(A) in subparagraph (B)(iii), by striking ''provides not more than'' and inserting ''subject to subparagraph (F), provides not more than''; and

(B) by adding at the end the following new subparagraph:

''(F) ALTERNATIVE TO 25 INPATIENT BED LIMIT REQUIREMENT.—

''(i) IN GENERAL.—A State may elect to treat a facility, with respect to the designation of the facility for a cost reporting period, as satisfying the requirement of subparagraph (B)(iii) relating to a maximum number of acute care inpatient beds if the facility elects, in accordance with a method specified by the Secretary and before the beginning of the cost reporting period, to meet the requirement under clause (ii).

''(ii) ALTERNATE REQUIREMENT.—The requirement under this clause, with respect to a facility and a cost reporting

period, is that the total number of inpatient bed days described in subparagraph (B)(iii) during such period will not exceed 7,300. For purposes of this subparagraph, an individual who is an inpatient in a bed in the facility for a single day shall be counted as one inpatient bed day.

''(iii) WITHDRAWAL OF ELECTION.—The option described in clause (i) shall not apply to a facility for a cost reporting period if the facility (for any two consecutive cost reporting periods during the previous 5 cost reporting periods) was treated under such option and had a total number of inpatient bed days for each of such two cost reporting periods that exceeded the number specified in such clause.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to cost reporting periods beginning on or after the date of the enactment of this Act.

SEC. 523. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES UNDER PART B OF THE MEDICARE PROGRAM.

(a) COVERAGE OF SERVICES.—

(1) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(A) in subparagraph (DD), by striking ''and'' at the end;

(B) in subparagraph (EE), by inserting ''and'' at the end; and

(C) by adding at the end the following new subparagraph:

''(FF) marriage and family therapist services (as defined in subsection (ccc)(1)) and mental health counselor services (as defined in subsection (hhh)(3));''.

(2) DEFINITIONS.—Section 1861 of such Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Marriage and Family Therapist Services; Marriage and Family Therapist; Mental Health Counselor Services; Mental Health Counselor

''(hhh)(1) The term 'marriage and family therapist services' means services performed by a marriage and

family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

''(C) in the case of an individual performing services in a State that provides for licensure or certification of marriage and family therapists, is licensed or certified as a marriage and family therapist in such State.

''(3) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (4)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(4) The term 'mental health counselor' means an individual who—

''(A) possesses a master's or doctor's degree in mental health counseling or a related field;

''(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

''(C) in the case of an individual performing services in a State that provides for licensure or certification of mental health counselors or professional counselors, is licensed or certified as a mental health counselor or professional counselor in such State.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of such Act (42 U.S.C.

1395k(a)(2)(B)) is amended by adding at the end the following new clause:

"(v) marriage and family therapist services and mental health counselor services;".

(4) AMOUNT OF PAYMENT.—Section 1833(a)(1) of such Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking "and (W)" and inserting "(W)"; and

(B) by inserting before the semicolon at the end the following: ", and (X) with respect to marriage and family therapist services and mental health counselor services under section 1861(s)(2)(FF), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or 75 percent of the amount determined for payment of a psychologist under subparagraph (L)".

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of such Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting "marriage and family therapist services (as defined in

section 1861(hhh)(1)), mental health counselor services (as defined in section 1861(hhh)(3)),'' after ''qualified psychologist services,''.

(6) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of such Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clauses:

''(vii) A marriage and family therapist (as defined in section 1861(hhh)(2)).

''(viii) A mental health counselor (as defined in section 1861(hhh)(4)).''.

(b) COVERAGE OF CERTAIN MENTAL HEALTH SERVICES PROVIDED IN CERTAIN SETTINGS.—

(1) RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''or by a clinical social worker (as defined in subsection (hh)(1)),'' and inserting '', by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (hhh)(2)), or by a mental health counselor (as defined in subsection (hhh)(4)),''.

(2) HOSPICE PROGRAMS.—Section 1861(dd)(2)(B)(i)(III) of such Act (42 U.S.C. 1395x(dd)(2)(B)(i)(III)) is amended by inserting ''or one marriage and family therapist (as defined in subsection (hhh)(2))'' after ''social worker''.

(c) AUTHORIZATION OF MARRIAGE AND FAMILY THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-HOSPITAL SERVICES.—Section 1861(ee)(2)(G) of the Social Security Act (42 U.S.C. 1395x(ee)(2)(G)) is amended by inserting ''marriage and family therapist (as defined in subsection (hhh)(2)),'' after ''social worker,''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 2010.

SEC. 524. ESTABLISHMENT OF RURAL COMMUNITY HOSPITAL (RCH) PROGRAM.

(a) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 523, is amended by adding at the end of the following new subsection:

''Rural Community Hospital; Rural Community Hospital Services

''(iii)(1) The term 'rural community hospital' means a hospital (as defined in subsection (e)) that—

''(A) is located in a rural area (as defined in section 1886(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E);

''(B) subject to paragraph (2), has less than 51 acute care inpatient beds, as reported in its most recent cost report;

''(C) makes available 24-hour emergency care services;

''(D) subject to paragraph (3), has a provider agreement in effect with the Secretary and is open to the public as of January 1, 2010; and

''(E) applies to the Secretary for such designation.

''(2) For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

''(3) Subparagraph (1)(D) shall not be construed to prohibit any of the following from qualifying as a rural community hospital:

''(A) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2010) with the same service area (as defined by the Secretary in regulations in effect on such date).

''(B) A facility obtaining a new provider number pursuant to a change of ownership.

''(C) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of a building as of January 1, 2010.

''(4) Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under subsection (e) and section 1866.

''(5) Nothing in this subsection shall be construed as prohibiting a rural community hospital participating in the demonstration program under Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2313) from qualifying as a rural community hospital if the rural community hospital meets the conditions otherwise applicable to hospitals under subsection (e) and section 1866.''.

(b) PAYMENT.—

(1) INPATIENT HOSPITAL SERVICES.—Section 1814 of the Social Security Act (42 U.S.C. 1395f) is amended by adding at the end the following new subsection:

''Payment for Inpatient Services Furnished in Rural Community Hospitals

''(m) The amount of payment under this part for inpatient hospital services furnished in a rural community hospital, other than such services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital in the application referred to in section 1861(iii)(1)(E)—

''(1) 101 percent of the reasonable costs of providing such services, without regard to the amount of the customary or other charge, or

''(2) the amount of payment provided for under the prospective payment system for inpatient hospital services under section 1886(d).''.

(2) OUTPATIENT SERVICES.—Section 1834 of such Act (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(n) PAYMENT FOR OUTPATIENT SERVICES FURNISHED IN RURAL COMMUNITY HOSPITALS.—The amount of payment under this part for outpatient services furnished in a rural community hospital is, at the election of the hospital in the application referred to in section 1861(iii)(1)(E)—

''(1) 101 percent of the reasonable costs of providing such services, without regard to the amount

of the customary or other charge and any limitation under section 1861(v)(1)(U), or

''(2) the amount of payment provided for under the prospective payment system for covered OPD services under section 1833(t).''.

(3) EXEMPTION FROM 30-PERCENT REDUCTION IN REIMBURSEMENT FOR BAD DEBT.—Section 1861(v)(1)(T) of such Act (42 U.S.C. 1395x(v)(1)(T)) is amended by inserting ''(other than for a rural community hospital)'' after ''In determining such reasonable costs for hospitals''.

(c) BENEFICIARY COST-SHARING FOR OUTPATIENT SERVICES.—Section 1834(n) of such Act (as added by subsection (b)(2)) is amended—

(1) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(2) by inserting ''(1)'' after ''(n)''; and

(3) by adding at the end the following:

''(2) The amounts of beneficiary cost-sharing for outpatient services furnished in a rural community hospital under this part shall be as follows:

''(A) For items and services that would have been paid under section 1833(t) if provided by a hospital, the amount of cost-sharing determined under paragraph (8) of such section.

''(B) For items and services that would have been paid under section 1833(h) if furnished by a provider or supplier, no cost-sharing shall apply.

''(C) For all other items and services, the amount of cost-sharing that would apply to the item or service under the methodology that would be used to determine payment for such item or service if provided by a physician, provider, or supplier, as the case may be.''.

(d) CONFORMING AMENDMENTS.—

(1) PART A PAYMENT.—Section 1814(b) of such Act (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by inserting ''other than inpatient hospital services furnished by a rural community hospital,'' after ''critical access hospital services,''.

(2) PART B PAYMENT.—Section 1833(a) of such Act (42 U.S.C. 1395l(a)) is amended—

(A) in paragraph (2), in the matter before subparagraph (A), by striking ''and (I)'' and inserting ''(I), and (K)'';

(B) by striking ''and'' at the end of paragraph (8);

(C) by striking the period at the end of paragraph (9) and inserting ''; and''; and

(D) by adding at the end the following:

''(10) in the case of outpatient services furnished by a rural community hospital, the amounts described in section 1834(n).''.

(3) TECHNICAL AMENDMENTS.—

(A) CONSULTATION WITH STATE AGENCIES.—Section 1863 of such Act (42 U.S.C. 1395z) is amended by striking ''and (dd)(2)'' and inserting ''(dd)(2), (mm)(1), and (iii)(1)''.

(B) PROVIDER AGREEMENTS.—Section 1866(a)(2)(A) of such Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by inserting ''section 1834(n)(2),'' after ''section 1833(b),''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2009.

SEC. 525. MEDICARE REMOTE MONITORING PILOT PROJECTS.

(a) PILOT PROJECTS.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct pilot projects under title XVIII of the Social Security Act for the purpose of providing incentives to

home health agencies to utilize home monitoring and communications technologies that—

(A) enhance health outcomes for Medicare beneficiaries; and

(B) reduce expenditures under such title.

(2) SITE REQUIREMENTS.—

(A) URBAN AND RURAL.—The Secretary shall conduct the pilot projects under this section in both urban and rural areas.

(B) SITE IN A SMALL STATE.—The Secretary shall conduct at least 3 of the pilot projects in a State with a population of less than 1,000,000.

(3) DEFINITION OF HOME HEALTH AGENCY.—In this section, the term ''home health agency'' has the meaning given that term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(b) MEDICARE BENEFICIARIES WITHIN THE SCOPE OF PROJECTS.—The Secretary shall specify the criteria for identifying those Medicare beneficiaries who shall be considered within the scope of the pilot projects under this section for purposes of the application of subsection (c) and for the assessment of the effectiveness of the home health agency in achieving the objectives of this section. Such criteria may provide for the inclusion in the projects

of Medicare beneficiaries who begin receiving home health services under title XVIII of the Social Security Act after the date of the implementation of the projects.

(c) INCENTIVES.—

(1) PERFORMANCE TARGETS.—The Secretary shall establish for each home health agency participating in a pilot project under this section a performance target using one of the following methodologies, as determined appropriate by the Secretary:

(A) ADJUSTED HISTORICAL PERFORMANCE TARGET.—The Secretary shall establish for the agency—

(i) a base expenditure amount equal to the average total payments made to the agency under parts A and B of title XVIII of the Social Security Act for Medicare beneficiaries determined to be within the scope of the pilot project in a base period determined by the Secretary; and

(ii) an annual per capita expenditure target for such beneficiaries, reflecting the base expenditure amount adjusted for risk and adjusted growth rates.

(B) COMPARATIVE PERFORMANCE TARGET.—The Secretary shall establish for the agency a comparative performance target equal to the average total payments under such parts A and B during the pilot project for comparable individuals in the same geographic area that are not determined to be within the scope of the pilot project.

(2) INCENTIVE.—Subject to paragraph (3), the Secretary shall pay to each participating home care agency an incentive payment for each year under the pilot project equal to a portion of the Medicare savings realized for such year relative to the performance target under paragraph (1).

(3) LIMITATION ON EXPENDITURES.—The Secretary shall limit incentive payments under this section in order to ensure that the aggregate expenditures under title XVIII of the Social Security Act (including incentive payments under this subsection) do not exceed the amount that the Secretary estimates would have been expended if the pilot projects under this section had not been implemented.

(d) WAIVER AUTHORITY.—The Secretary may waive such provisions of titles XI and XVIII of the Social Secu-

rity Act as the Secretary determines to be appropriate for the conduct of the pilot projects under this section.

(e) REPORT TO CONGRESS.—Not later than 5 years after the date that the first pilot project under this section is implemented, the Secretary shall submit to Congress a report on the pilot projects. Such report shall contain a detailed description of issues related to the expansion of the projects under subsection (f) and recommendations for such legislation and administrative actions as the Secretary considers appropriate.

(f) EXPANSION.—If the Secretary determines that any of the pilot projects under this section enhance health outcomes for Medicare beneficiaries and reduce expenditures under title XVIII of the Social Security Act, the Secretary may initiate comparable projects in additional areas.

(g) INCENTIVE PAYMENTS HAVE NO EFFECT ON OTHER MEDICARE PAYMENTS TO AGENCIES.—An incentive payment under this section—

(1) shall be in addition to the payments that a home health agency would otherwise receive under title XVIII of the Social Security Act for the provision of home health services; and

(2) shall have no effect on the amount of such payments.

SEC. 526. RURAL HEALTH QUALITY ADVISORY COMMISSION AND DEMONSTRATION PROJECTS.

(a) RURAL HEALTH QUALITY ADVISORY COMMISSION.—

(1) ESTABLISHMENT.—Not later than 6 months after the date of the enactment of this section, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a commission to be known as the Rural Health Quality Advisory Commission (in this section referred to as the ''Commission'').

(2) DUTIES OF COMMISSION.—

(A) NATIONAL PLAN.—The Commission shall develop, coordinate, and facilitate implementation of a national plan for rural health quality improvement. The national plan shall—

(i) identify objectives for rural health quality improvement;

(ii) identify strategies to eliminate known gaps in rural health system capacity and improve rural health quality; and

(iii) provide for Federal programs to identify opportunities for strengthening and aligning policies and programs to improve rural health quality.

(B) DEMONSTRATION PROJECTS.—The Commission shall design demonstration projects to test alternative models for rural health quality improvement, including with respect to both personal and population health.

(C) MONITORING.—The Commission shall monitor progress toward the objectives identified pursuant to paragraph (1)(A).

(3) MEMBERSHIP.—

(A) NUMBER.—The Commission shall be composed of 11 members appointed by the Secretary.

(B) SELECTION.—The Secretary shall select the members of the Commission from among individuals with significant rural health care and health care quality expertise, including expertise in clinical health care, health care quality research, population or public health, or purchaser organizations.

(4) CONTRACTING AUTHORITY.—Subject to the availability of funds, the Commission may enter into contracts and make other arrangements, as may be necessary to carry out the duties described in paragraph (2).

(5) STAFF.—Upon the request of the Commission, the Secretary may detail, on a reimbursable basis, any of the personnel of the Office of Rural Health Policy of the Health Resources and Services Administration, the Agency for Health Care Quality and Research, or the Centers for Medicare & Medicaid Services to the Commission to assist in carrying out this subsection.

(6) REPORTS TO CONGRESS.—Not later than 1 year after the establishment of the Commission, and annually thereafter, the Commission shall submit a report to the Congress on rural health quality. Each such report shall include the following:

(A) An inventory of relevant programs and recommendations for improved coordination and integration of policy and programs.

(B) An assessment of achievement of the objectives identified in the national plan developed under paragraph (2) and recommendations for realizing such objectives.

(C) Recommendations on Federal legislation, regulations, or administrative policies to enhance rural health quality and outcomes.

(b) RURAL HEALTH QUALITY DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Not later than 270 days after the date of the enactment of this section, the Secretary, in consultation with the Rural Health Quality Advisory Commission, the Office of Rural Health Policy of the Health Resources and Services Administration, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services, shall make grants to eligible entities for 5 demonstration projects to implement and evaluate methods for improving the quality of health care in rural communities. Each such demonstration project shall include—

(A) alternative community models that—

(i) will achieve greater integration of personal and population health services; and

(ii) address safety, effectiveness, patient- or community-centeredness, timeliness, efficiency, and equity (the six aims identified by the Institute of Medicine of the National Academies in its report entitled ''Crossing the Quality Chasm: A New Health System for the 21st Century'' released on March 1, 2001);

(B) innovative approaches to the financing and delivery of health services to achieve rural health quality goals; and

(C) development of quality improvement support structures to assist rural health systems and professionals (such as workforce support structures, quality monitoring and reporting, clinical care protocols, and information technology applications).

(2) ELIGIBLE ENTITIES.—In this subsection, the term ''eligible entity'' means a consortium that—

(A) shall include—

(i) at least one health care provider or health care delivery system located in a rural area; and

(ii) at least one organization representing multiple community stakeholders; and

(B) may include other partners such as rural research centers.

(3) CONSULTATION.—In developing the program for awarding grants under this subsection, the Secretary shall consult with the Administrator of the Agency for Healthcare Research and Quality, rural

health care providers, rural health care researchers, and private and non-profit groups (including national associations) which are undertaking similar efforts.

(4) EXPEDITED WAIVERS.—The Secretary shall expedite the processing of any waiver that—

(A) is authorized under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.); and

(B) is necessary to carry out a demonstration project under this subsection.

(5) DEMONSTRATION PROJECT SITES.—The Secretary shall ensure that the 5 demonstration projects funded under this subsection are conducted at a variety of sites representing the diversity of rural communities in the Nation.

(6) DURATION.—Each demonstration project under this subsection shall be for a period of 4 years.

(7) INDEPENDENT EVALUATION.—The Secretary shall enter into an arrangement with an entity that has experience working directly with rural health systems for the conduct of an independent evaluation of the program carried out under this subsection.

(8) REPORT.—Not later than one year after the conclusion of all of the demonstration projects funded under this subsection, the Secretary shall submit a report to the Congress on the results of such projects. The report shall include—

(A) an evaluation of patient access to care, patient outcomes, and an analysis of the cost effectiveness of each such project; and

(B) recommendations on Federal legislation, regulations, or administrative policies to enhance rural health quality and outcomes.

(c) APPROPRIATION.—

(1) IN GENERAL.—Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this section $30,000,000 for the period of fiscal years 2010 through 2014.

(2) AVAILABILITY.—

(A) IN GENERAL.—Funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2014.

(B) REPORT.—For purposes of carrying out subsection (b)(8), funds appropriated under paragraph (1) shall remain available for expenditure through fiscal year 2015.

(3) RESERVATION.—Of the amount appropriated under paragraph (1), the Secretary shall reserve—

(A) $5,000,000 to carry out subsection (a); and

(B) $25,000,000 to carry out subsection (b), of which—

(i) 2 percent shall be for the provision of technical assistance to grant recipients; and

(ii) 5 percent shall be for independent evaluation under subsection (b)(7).

SEC. 527. RURAL HEALTH CARE SERVICES.

Section 330A of the Public Health Service Act (42 U.S.C. 254c) is amended to read as follows:

"SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH, RURAL HEALTH NETWORK DEVELOPMENT, DELTA RURAL DISPARITIES AND HEALTH SYSTEMS DEVELOPMENT, AND SMALL RURAL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANT PROGRAMS.

''(a) PURPOSE.—The purpose of this section is to provide for grants—

''(1) under subsection (b), to promote rural health care services outreach;

''(2) under subsection (c), to provide for the planning and implementation of integrated health care networks in rural areas;

''(3) under subsection (d), to assist rural communities in the Delta Region to reduce health disparities and to promote and enhance health system development; and

''(4) under subsection (e), to provide for the planning and implementation of small rural health care provider quality improvement activities.

''(b) RURAL HEALTH CARE SERVICES OUTREACH GRANTS.—

''(1) GRANTS.—The Director of the Office of Rural Health Policy of the Health Resources and Services Administration may award grants to eligible entities to promote rural health care services outreach by expanding the delivery of health care services to include new and enhanced services in rural areas. The Director may award the grants for periods of not more than 3 years.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection for a project, an entity—

''(A) shall be a rural public or rural nonprofit private entity, a facility that qualifies as

a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a tribal government whose grant-funded activities will be conducted within federally recognized tribal areas;

''(B) shall represent a consortium composed of members—

''(i) that include 3 or more independently owned health care entities; and

''(ii) that may be nonprofit or for-profit entities; and

''(C) shall not previously have received a grant under this subsection for the same or a similar project, unless the entity is proposing to expand the scope of the project or the area that will be served through the project.

''(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

"(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

"(B) a description of the manner in which the project funded under the grant will meet the health care needs of rural populations in the local community or region to be served;

"(C) a plan for quantifying how health care needs will be met through identification of the target population and benchmarks of service delivery or health status, such as—

"(i) quantifiable measurements of health status improvement for projects focusing on health promotion; or

"(ii) benchmarks of increased access to primary care, including tracking factors such as the number and type of primary care visits, identification of a medical home, or other general measures of such access;

"(D) a description of how the local community or region to be served will be involved in the development and ongoing operations of the project;

"(E) a plan for sustaining the project after Federal support for the project has ended;

"(F) a description of how the project will be evaluated;

"(G) the administrative capacity to submit annual performance data electronically as specified by the Director; and

"(H) other such information as the Director determines to be appropriate.

"(c) RURAL HEALTH NETWORK DEVELOPMENT GRANTS.—

"(1) GRANTS.—

"(A) IN GENERAL.—The Director may award rural health network development grants to eligible entities to promote, through planning and implementation, the development of integrated health care networks that have combined the functions of the entities participating in the networks in order to—

"(i) achieve efficiencies and economies of scale;

"(ii) expand access to, coordinate, and improve the quality of the health care delivery system through development of organizational efficiencies;

''(iii) implement health information technology to achieve efficiencies, reduce medical errors, and improve quality;

''(iv) coordinate care and manage chronic illness; and

''(v) strengthen the rural health care system as a whole in such a manner as to show a quantifiable return on investment to the participants in the network.

''(B) GRANT PERIODS.—The Director may award such a rural health network development grant—

''(i) for a period of 3 years for implementation activities; or

''(ii) for a period of 1 year for planning activities to assist in the initial development of an integrated health care network, if the proposed participants in the network do not have a history of collaborative efforts and a 3-year grant would be inappropriate.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an entity—

''(A) shall be a rural public or rural nonprofit private entity, a facility that qualifies as

a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services to migrant and seasonal farm workers in rural areas, or a tribal government whose grant-funded activities will be conducted within federally recognized tribal areas;

''(B) shall represent a network composed of participants—

''(i) that include 3 or more independently owned health care entities; and

''(ii) that may be nonprofit or for-profit entities; and

''(C) shall not previously have received a grant under this subsection (other than a 1-year grant for planning activities) for the same or a similar project.

''(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity, in consultation with the appropriate State office of rural health or another appropriate State entity, shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

"(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

"(B) an explanation of the reasons why Federal assistance is required to carry out the project;

"(C) a description of—

"(i) the history of collaborative activities carried out by the participants in the network;

"(ii) the degree to which the participants are ready to integrate their functions; and

"(iii) how the local community or region to be served will benefit from and be involved in the activities carried out by the network;

"(D) a description of how the local community or region to be served will experience increased access to quality health care services across the continuum of care as a result of the integration activities carried out by the network, including a description of—

"(i) return on investment for the community and the network members; and

''(ii) other quantifiable performance measures that show the benefit of the network activities;

''(E) a plan for sustaining the project after Federal support for the project has ended;

''(F) a description of how the project will be evaluated;

''(G) the administrative capacity to submit annual performance data electronically as specified by the Director; and

''(H) other such information as the Director determines to be appropriate.

''(d) DELTA RURAL DISPARITIES AND HEALTH SYSTEMS DEVELOPMENT GRANTS.—

''(1) GRANTS.—The Director may award grants to eligible entities to support reduction of health disparities, improve access to health care, and enhance rural health system development in the Delta Region.

''(2) ELIGIBILITY.—To be eligible to receive a grant under this subsection, an entity shall be a rural public or rural nonprofit private entity, a facility that qualifies as a rural health clinic under title XVIII of the Social Security Act, a public or nonprofit entity existing exclusively to provide services

to migrant and seasonal farm workers in rural areas, or a tribal government whose grant-funded activities will be conducted within federally recognized tribal areas.

''(3) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

''(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

''(B) an explanation of the reasons why Federal assistance is required to carry out the project;

''(C) a description of the manner in which the project funded under the grant will meet the health care needs of the Delta Region;

''(D) a description of how the local community or region to be served will experience increased access to quality health care services as a result of the activities carried out by the entity;

"(E) a description of how health disparities will be reduced or the health system will be improved;

"(F) a plan for sustaining the project after Federal support for the project has ended;

"(G) a description of how the project will be evaluated including process and outcome measures related to the quality of care provided or how the health care system improves its performance;

"(H) a description of how the grantee will develop an advisory group made up of representatives of the communities to be served to provide guidance to the grantee to best meet community need; and

"(I) other such information as the Director determines to be appropriate.

"(e) SMALL RURAL HEALTH CARE PROVIDER QUALITY IMPROVEMENT GRANTS.—

"(1) GRANTS.—The Director may award grants to provide for the planning and implementation of small rural health care provider quality improvement activities. The Director may award the grants for periods of 1 to 3 years.

''(2) ELIGIBILITY.—To be eligible for a grant under this subsection, an entity—

''(A) shall be—

''(i) a rural public or rural nonprofit private health care provider or provider of health care services, such as a rural health clinic; or

''(ii) another rural provider or network of small rural providers identified by the Director as a key source of local care; and

''(B) shall not previously have received a grant under this subsection for the same or a similar project.

''(3) PREFERENCE.—In awarding grants under this subsection, the Director shall give preference to facilities that qualify as rural health clinics under title XVIII of the Social Security Act.

''(4) APPLICATIONS.—To be eligible to receive a grant under this subsection, an eligible entity shall prepare and submit to the Director an application at such time, in such manner, and containing such information as the Director may require, including—

"(A) a description of the project that the eligible entity will carry out using the funds provided under the grant;

"(B) an explanation of the reasons why Federal assistance is required to carry out the project;

"(C) a description of the manner in which the project funded under the grant will assure continuous quality improvement in the provision of services by the entity;

"(D) a description of how the local community or region to be served will experience increased access to quality health care services as a result of the activities carried out by the entity;

"(E) a plan for sustaining the project after Federal support for the project has ended;

"(F) a description of how the project will be evaluated including process and outcome measures related to the quality of care provided; and

"(G) other such information as the Director determines to be appropriate.

"(f) GENERAL REQUIREMENTS.—

''(1) PROHIBITED USES OF FUNDS.—An entity that receives a grant under this section may not use funds provided through the grant—

''(A) to build or acquire real property; or

''(B) for construction.

''(2) COORDINATION WITH OTHER AGENCIES.—The Director shall coordinate activities carried out under grant programs described in this section, to the extent practicable, with Federal and State agencies and nonprofit organizations that are operating similar grant programs, to maximize the effect of public dollars in funding meritorious proposals.

''(g) REPORT.—Not later than September 30, 2012, the Secretary shall prepare and submit to the appropriate committees of Congress a report on the progress and accomplishments of the grant programs described in subsections (b), (c), (d), and (e).

''(h) DEFINITIONS.—In this section:

''(1) The term 'Delta Region' has the meaning given to the term 'region' in section 382A of the Consolidated Farm and Rural Development Act (7 U.S.C. 2009aa).

''(2) The term 'Director' means the Director of the Office of Rural Health Policy of the Health Resources and Services Administration.

''(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $40,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014.''.

SEC. 528. COMMUNITY HEALTH CENTER COLLABORATIVE ACCESS EXPANSION.

Section 330 of the Public Health Service Act (42 U.S.C. 254b) is amended by adding at the end the following:

''(s) MISCELLANEOUS PROVISIONS.—

''(1) RULE OF CONSTRUCTION WITH RESPECT TO RURAL HEALTH CLINICS.—

''(A) IN GENERAL.—Nothing in this section shall be construed to prevent a community health center from contracting with a federally certified rural health clinic (as defined by section 1861(aa)(2) of the Social Security Act) for the delivery of primary health care services that are available at the rural health clinic to individuals who would otherwise be eligible for free or reduced cost care if that individual were able to obtain that care at the community health center. Such services may be limited in scope to those primary health care services available in that rural health clinic.

''(B) ASSURANCES.—In order for a rural health clinic to receive funds under this section through a contract with a community health center under paragraph (1), such rural health clinic shall establish policies to ensure—

''(i) nondiscrimination based upon the ability of a patient to pay; and

''(ii) the establishment of a sliding fee scale for low-income patients.''.

SEC. 529. FACILITATING THE PROVISION OF TELEHEALTH SERVICES ACROSS STATE LINES.

(a) IN GENERAL.—For purposes of expediting the provision of telehealth services, for which payment is made under the Medicare program, across State lines, the Secretary of Health and Human Services shall, in consultation with representatives of States, physicians, health care practitioners, and patient advocates, encourage and facilitate the adoption of provisions allowing for multistate practitioner practice across State lines.

(b) DEFINITIONS.—In subsection (a):

(1) TELEHEALTH SERVICE.—The term ''telehealth service'' has the meaning given that term in subparagraph (F) of section 1834(m)(4) of the Social Security Act (42 U.S.C. 1395m(m)(4)).

(2) PHYSICIAN, PRACTITIONER.—The terms ''physician'' and ''practitioner'' have the meaning given those terms in subparagraphs (D) and (E), respectively, of such section.

(3) MEDICARE PROGRAM.—The term ''Medicare program'' means the program of health insurance administered by the Secretary of Health and Human Services under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

SEC. 530. REMOVING BARRIERS TO HEALTH CARE AND NUTRITION ASSISTANCE HEALTH COVERAGE FOR CHILDREN, PREGNANT WOMEN, AND LAWFULLY RESIDING INDIVIDUALS.

(a) MEDICAID.—Section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)) is amended by striking paragraph (4) and inserting the following new paragraph:

''(4)(A) Notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, payment shall be made under this section for care and services that are furnished to individuals, including those described in paragraph (1), if they otherwise meet the eligibility requirements for medical assistance under the State plan approved under this title (other than the requirement of the receipt of aid or assistance under title IV, supplemental

security income benefits under title XVI, or a State supplementary payment), and are—

''(i) lawfully present in the United States;

''(ii) children under age 21, including optional targeted low-income children described in section 1905(u)(2)(B); or

''(iii) pregnant women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

''(B) No debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.''.

(b) SCHIP.—Section 2107(e)(1) of the Social Security Act (42 U.S.C. 1397gg(e)(1)) is amended by striking subparagraph (H) and inserting the following new subparagraph:

''(H) Paragraph (4) of section 1903(v) (relating to individuals who, but for sections 401(a), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, would be eligible for medical assistance under title XXI).''.

(c) NUTRITION ASSISTANCE.—

(1) SUPPLEMENTAL NUTRITION ASSISTANCE.—Notwithstanding sections 401(a), 402(a), and 403(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(a); 1612(a), 1613(a)) and section 6(f) of the Food and Nutrition Act of 2008 (7 U.S.C 2015(f)), persons who are lawfully present in the United States shall be not be ineligible for benefits under the supplemental nutrition assistance program on the basis of their immigration status or date of entry into the United States.

(2) ELIGIBILITY FOR FAMILIES WITH CHILDREN.—Section of the 421(d)(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631(d)(3)) is amended by striking ''to the extent that a qualified alien is eligible under section 402(a)(2)(J)'' and inserting, ''to the extent that a child is a member of a household under the supplemental nutrition assistance program''.

(3) ENSURING PROPER SCREENING.—Section 11(e)(2)(B) of the Food and Nutrition Act of 2008 (7 U.S.C. 2020(e)(2)(B)) is amended—

(A) by redesignating clauses (vi) and (viii) as clauses (vii) and (viii); and

(B) by inserting after clause (v) the following:

''(vi) shall provide a method for implementing section 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631) that does not require any unnecessary information from persons who may be exempt from that provision;''.

SEC. 531. REMOVING MEDICARE BARRIER TO HEALTH CARE.

Section 1818(a)(3) of the Social Security Act (42 U.S.C. 1395i–2(a)(3)) is amended by amending clause (B) to read as follows: ''(B) an individual who is lawfully present in the United States''.

CHAPTER 2—LUNG CANCER MORTALITY REDUCTION

SEC. 541. SHORT TITLE.

This chapter may be cited as the ''Lung Cancer Mortality Reduction Act of 2009''.

SEC. 542. FINDINGS.

Congress makes the following findings:

(1) Lung cancer is the leading cause of cancer death for both men and women, accounting for 28 percent of all cancer deaths.

(2) Lung cancer kills more people annually than breast cancer, prostate cancer, colon cancer, liver cancer, melanoma, and kidney cancer combined.

(3) Since the National Cancer Act of 1971 (Public Law 92–218; 85 Stat. 778), coordinated and comprehensive research has raised the 5-year survival rates for breast cancer to 88 percent, for prostate cancer to 99 percent, and for colon cancer to 64 percent.

(4) However, the 5-year survival rate for lung cancer is still only 15 percent and a similar coordinated and comprehensive research effort is required to achieve increases in lung cancer survivability rates.

(5) Sixty percent of lung cancer cases are now diagnosed as nonsmokers or former smokers.

(6) Two-thirds of nonsmokers diagnosed with lung cancer are women.

(7) Certain minority populations, such as African-American males, have disproportionately high rates of lung cancer incidence and mortality, notwithstanding their similar smoking rate.

(8) Members of the baby boomer generation are entering their sixties, the most common age at which people develop lung cancer.

(9) Tobacco addiction and exposure to other lung cancer carcinogens such as Agent Orange and other herbicides and battlefield emissions are serious problems among military personnel and war veterans.

(10) Significant and rapid improvements in lung cancer mortality can be expected through greater use and access to lung cancer screening tests for at-risk individuals.

(11) Additional strategies are necessary to further enhance the existing tests and therapies available to diagnose and treat lung cancer in the future.

(12) The August 2001 Report of the Lung Cancer Progress Review Group of the National Cancer Institute stated that funding for lung cancer research was ''far below the levels characterized for other common malignancies and far out of proportion to its massive health impact''.

(13) The Report of the Lung Cancer Progress Review Group identified as its ''highest priority'' the creation of integrated, multidisciplinary, multi-institutional research consortia organized around the problem of lung cancer rather than around specific research disciplines.

(14) The United States must enhance its response to the issues raised in the Report of the Lung Cancer Progress Review Group, and this can be accomplished through the establishment of a coordinated effort designed to reduce the lung cancer mortality rate by 50 percent by 2015 and targeted funding to support this coordinated effort.

SEC. 543. SENSE OF CONGRESS CONCERNING INVESTMENT IN LUNG CANCER RESEARCH.

It is the sense of the Congress that—

(1) lung cancer mortality reduction should be made a national public health priority; and

(2) a comprehensive mortality reduction program coordinated by the Secretary of Health and Human Services is justified and necessary to adequately address and reduce lung cancer mortality.

SEC. 544. LUNG CANCER MORTALITY REDUCTION PROGRAM.

(a) IN GENERAL.—Subpart 1 of part C of title IV of the Public Health Service Act (42 U.S.C. 285 et seq.) is amended by adding at the end the following:

"SEC. 417G. LUNG CANCER MORTALITY REDUCTION PROGRAM.

''(a) IN GENERAL.—Not later than 6 months after the date of the enactment of this section, the Secretary,

in consultation with the Secretary of Defense, the Secretary of Veterans Affairs, the Director of the National Institutes of Health, the Director of the Centers for Disease Control and Prevention, the Commissioner of Food and Drugs, the Administrator of the Centers for Medicare & Medicaid Services, the Director of the National Center on Minority Health and Health Disparities, and other members of the Lung Cancer Advisory Board established under section 546 of the Lung Cancer Mortality Reduction Act of 2009, shall implement a comprehensive program, to be known as the Lung Cancer Mortality Reduction Program, to achieve a reduction of at least 25 percent in the mortality rate of lung cancer by 2015.

''(b) REQUIREMENTS.—The Program shall include at least the following:

''(1) With respect to the National Institutes of Health—

''(A) a strategic review and prioritization by the National Cancer Institute of research grants to achieve the goal of the Lung Cancer Mortality Reduction Program in reducing lung cancer mortality;

''(B) the provision of funds to enable the Airway Biology and Disease Branch of the National Heart, Lung, and Blood Institute to ex-

pand its research programs to include predispositions to lung cancer, the interrelationship between lung cancer and other pulmonary and cardiac disease, and the diagnosis and treatment of these interrelationships;

''(C) the provision of funds to enable the National Institute of Biomedical Imaging and Bioengineering to expedite the development of computer assisted diagnostic, surgical, treatment, and drug testing innovations to reduce lung cancer mortality, such as through expansion of the Institute's Quantum Grant Program and Image-Guided Interventions programs; and

''(D) the provision of funds to enable the National Institute of Environmental Health Sciences to implement research programs relative to the lung cancer incidence.

''(2) With respect to the Food and Drug Administration—

''(A) activities under section 529 of the Federal Food, Drug, and Cosmetic Act; and

''(B) activities under section 561 of the Federal Food, Drug, and Cosmetic Act to expand access to investigational drugs and devices

for the diagnosis, monitoring, or treatment of lung cancer.

''(3) With respect to the Centers for Disease Control and Prevention, the establishment of an early disease research and management program under section 1511.

''(4) With respect to the Agency for Healthcare Research and Quality, the conduct of a biannual review of lung cancer screening, diagnostic, and treatment protocols, and the issuance of updated guidelines.

''(5) The cooperation and coordination of all minority and health disparity programs within the Department of Health and Human Services to ensure that all aspects of the Lung Cancer Mortality Reduction Program under this section adequately address the burden of lung cancer on minority and rural populations.

''(6) The cooperation and coordination of all tobacco control and cessation programs within agencies of the Department of Health and Human Services to achieve the goals of the Lung Cancer Mortality Reduction Program under this section with particular emphasis on the coordination of drug and

other cessation treatments with early detection protocols.''.

(b) FEDERAL FOOD, DRUG, AND COSMETIC ACT.—Subchapter B of chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360aaa et seq.) is amended by adding at the end the following:

''DRUGS RELATING TO LUNG CANCER

''SEC. 529. (a) IN GENERAL.—The provisions of this subchapter shall apply to a drug described in subsection (b) to the same extent and in the same manner as such provisions apply to a drug for a rare disease or condition.

''(b) QUALIFIED DRUGS.—A drug described in this subsection is—

''(1) a chemoprevention drug for precancerous conditions of the lung;

''(2) a drug for a targeted therapeutic treatments, including any vaccine for, lung cancer; and

''(3) a drug to curtail or prevent nicotine addiction.

''(c) BOARD.—The Board established under section 546 of the Lung Cancer Mortality Reduction Act of 2009 shall monitor the program implemented under this section.''.

(c) ACCESS TO UNAPPROVED THERAPIES.—Section 561(e) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360bbb(e)) is amended by inserting before the pe-

riod the following: ''and shall include expanding access to drugs under section 529, with substantial consideration being given to whether the totality of information available to the Secretary regarding the safety and effectiveness of an investigational drug, as compared to the risk of morbidity and death from the disease, indicates that a patient may obtain more benefit than risk if treated with the drug''.

(d) CDC.—Title XV of the Public Health Service Act (42 U.S.C. 300k et seq.) is amended by adding at the end the following:

''SEC. 1511. EARLY DISEASE RESEARCH AND MANAGEMENT PROGRAM.

''The Secretary shall establish and implement an early disease research and management program targeted at the high incidence and mortality rates of lung cancer among minority and low-income populations.''.

SEC. 545. DEPARTMENT OF DEFENSE AND THE DEPARTMENT OF VETERANS AFFAIRS.

The Secretary of Defense and the Secretary of Veterans Affairs shall coordinate with the Secretary of Health and Human Services—

(1) in the development of the Lung Cancer Mortality Reduction Program under section 417G;

(2) in the implementation within the Department of Defense and the Department of Veterans Affairs of an early detection and disease management research program for military personnel and veterans whose smoking history and exposure to carcinogens during active duty service has increased their risk for lung cancer; and

(3) in the implementation of coordinated care programs for military personnel and veterans diagnosed with lung cancer.

SEC. 546. LUNG CANCER ADVISORY BOARD.

(a) IN GENERAL.—The Secretary of Health and Human Services shall convene a Lung Cancer Advisory Board (referred to in this section as the ''Board'')—

(1) to monitor the programs established under this chapter (and the amendments made by this chapter); and

(2) to provide annual reports to the Congress concerning benchmarks, expenditures, lung cancer statistics, and the public health impact of such programs.

(b) COMPOSITION.—The Board shall be composed of—

(1) the Secretary of Health and Human Services;

(2) the Secretary of Defense;

(3) the Secretary of Veterans Affairs; and

(4) two representatives each from the fields of clinical medicine focused on lung cancer, lung cancer research, imaging, drug development, and lung cancer advocacy, to be appointed by the Secretary of Health and Human Services.

SEC. 547. AUTHORIZATION OF APPROPRIATIONS.

(a) IN GENERAL.—To carry out this chapter (and the amendments made by this chapter), there are authorized to be appropriated such sums as may be necessary for each of fiscal years 2010 through 2014.

(b) LUNG CANCER MORTALITY REDUCTION PROGRAM.—Of the amounts authorized to be appropriated by subsection (a), there are authorized to be appropriated—

(1) $25,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014, for the activities described in section 417G(b)(1)(B) of the Public Health Service Act, as added by section 544(a);

(2) $25,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014, for the activities described in section 417G(b)(1)(C) of such Act;

(3) $10,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014, for the activities described in section 417G(b)(1)(D) of such Act; and

(4) $15,000,000 for fiscal year 2010, and such sums as may be necessary for each of fiscal years 2011 through 2014, for the activities described in section 417G(b)(3) of such Act.

TITLE VI—ELIMINATING DISPARITIES IN DIABETES PREVENTION ACCESS AND CARE ACT

Subtitle A—NATIONAL INSTITUTES OF HEALTH

SEC. 611. RESEARCH, TREATMENT, AND EDUCATION.

(a) IN GENERAL.—Subpart 3 of part C of title IV of the Public Health Service Act (42 U.S.C. 285c et seq.) is amended by adding at the end the following new section:

"SEC. 434B. DIABETES IN MINORITY POPULATIONS.

''(a) IN GENERAL.—The Director of the National Institutes of Health shall expand, intensify, and support ongoing research and other activities with respect to pre-diabetes and diabetes, particularly type 2, in minority populations, including research to identify clinical, socio-

economic, geographical, cultural, and organizational factors that contribute to type 2 diabetes in such populations.

''(b) CERTAIN ACTIVITIES.—Activities under subsection (a) regarding type 2 diabetes in minority populations shall include the following:

''(1) Continue research on behavior and obesity, including research through the obesity research center that is sponsored by the National Institutes of Health.

''(2) Research on environmental factors that may contribute to the increase in type 2 diabetes.

''(3) Support for new methods to identify environmental triggers and genetic interactions that lead to the development of type 2 diabetes in minority newborns. Such research should follow the newborns through puberty, an increasingly high-risk period for developing type 2 diabetes.

''(4) Research to identify genes that predispose individuals to the onset of developing type 1 and type 2 diabetes and to the development of complications.

''(5) Research to prevent complications in individuals who have already developed diabetes, such as research that attempts to identify the genes that

predispose individuals with diabetes to the development of complications.

''(6) Research methods and alternative therapies to control blood glucose.

''(7) Support of ongoing research efforts examining the level of glycemia at which adverse outcomes develop during pregnancy and to address the many clinical issues associated with minority mothers and fetuses during diabetic and gestational diabetic pregnancies.

''(c) EDUCATION.—The Director of the National Institutes of Health shall—

''(1) through the National Center on Minority Health and Health Disparities and the National Diabetes Education Program—

''(A) make grants to programs funded under section 485F (relating to centers of excellence) for the purpose of establishing a mentoring program for health care professionals to be more involved in weight counseling, obesity research, and nutrition; and

''(B) provide for the participation of minority health professionals in diabetes-focused research programs; and

''(2) make grants for programs to establish a pipeline from high school to professional school that will increase minority representation in diabetes-focused health fields by expanding Minority Access to Research Careers (MARC) program internships and mentoring opportunities for recruitment.

''(d) DEFINITION.—For purposes of this section, the term 'minority population' means a racial and ethnic minority group, as defined in section 1707.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as are necessary for fiscal year 2010 and each subsequent fiscal year.''.

(b) DIABETES MELLITUS INTERAGENCY COORDINATING COMMITTEE.—Section 429 of the Public Health Service Act (42 U.S.C. 285c–3) is amended by adding at the end the following new subsection:

''(c)(1) In each annual report prepared by the Diabetes Mellitus Interagency Coordinating Committee, the Committee shall include an assessment of the Federal activities and programs related to diabetes in minority populations. Such assessment shall—

''(A) compile the current activities of all current Federal health programs to allow for the assessment of their adequacy as a systemic

method of addressing the impact of diabetes mellitus on minority populations;

"(B) develop strategic planning activities to develop an effective and comprehensive Federal plan to address diabetes mellitus within minority populations which will involve all appropriate Federal health programs and shall—

"(i) include steps to address issues including type 1 and type 2 diabetes in children and the disproportionate impact of diabetes mellitus on minority populations; and

"(ii) remain consistent with the programs and activities identified in section 399O, as well as remaining consistent with the intent of the Eliminating Disparities in Diabetes Prevention Access and Care Act of 2009; and

"(C) assess the implementation of such a plan throughout Federal health programs.

"(2) For the purposes of this subsection, the term 'minority population' means a racial and ethnic minority group, as defined in section 1707.

"(3) For the purpose of carrying out this subsection, there are authorized to be appropriated such

sums as are necessary for fiscal year 2010 and each subsequent fiscal year.''.

Subtitle B—CENTERS FOR DISEASE CONTROL AND PREVENTION

SEC. 621. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.

Part B of title III of the Public Health Service Act (42 U.S.C. 243 et seq.) is amended by inserting after section 317T the following section:

''SEC. 317U. DIABETES IN MINORITY POPULATIONS.

''(a) RESEARCH AND OTHER ACTIVITIES.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall conduct and support research and other activities with respect to diabetes in minority populations.

''(2) CERTAIN ACTIVITIES.—Activities under paragraph (1) regarding diabetes in minority populations shall include the following:

''(A) Expanding the National Diabetes Laboratory capacity for translational research and the identification of genetic and immunological risk factors associated with diabetes.

"(B) Enhancing the National Health and Nutrition Examination Survey to include risk factors for type 2 diabetes and pre-diabetes with emphasis on eating and dietary habits, and focus, including cultural and socioeconomic factors, on Hispanic-American, African-American, American Indian and Alaskan Native, and Asian-American, Native Hawaiian and other Pacific Islander communities.

"(C) Further enhancing the National Health and Nutrition Examination Survey by over-sampling Asian-American, Native Hawaiian, and Other Pacific Islanders in appropriate geographic areas to better determine the prevalence of diabetes in such populations as well as to improve the data collection of diabetes penetration disaggregated into major ethnic groups within such populations.

"(D) Within the Division of Diabetes Translation, providing for prevention research to better understand how to influence health care systems changes to improve quality of care being delivered to such populations, and within the Division of Diabetes Translation, carrying out model demonstration projects to design, im-

plement, and evaluate effective diabetes prevention and control intervention for such populations.

"(E) Through the Division of Diabetes Translation, carrying out culturally appropriate community-based interventions designed to address issues and problems experienced by such populations.

"(F) Conducting applied research within the Division of Diabetes Translation to reduce health disparities within such populations with diabetes.

"(G) Conducting applied research on primary prevention within the Division of Diabetes Translation to specifically focus on such populations with pre-diabetes.

"(b) EDUCATION.—

"(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall direct the Division of Diabetes Translation to conduct and support programs to educate the public on the causes and effects of diabetes in minority populations.

"(2) CERTAIN ACTIVITIES.—Programs under paragraph (1) regarding education on diabetes in

minority populations shall include carrying out public awareness campaigns directed toward such populations to aggressively emphasize the importance and impact of physical activity and diet in regard to diabetes and diabetes-related complications through the National Diabetes Education Program.

''(c) DIABETES; HEALTH PROMOTION, PREVENTION ACTIVITIES, AND ACCESS.—

''(1) IN GENERAL.—The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall carry out culturally appropriate diabetes health promotion and prevention programs for minority populations.

''(2) CERTAIN ACTIVITIES.—Activities regarding culturally appropriate diabetes health promotion and prevention programs for minority populations shall include the following:

''(A) Expanding the Diabetes Prevention and Control Program (currently existing in all the States and territories) and providing funds for education and community outreach on diabetes.

''(B) Providing funds for an expansion of the Diabetes Prevention Program Initiative that focuses on physical inactivity and diet and its

relation to type 2 diabetes within such populations.

''(C) Providing funds to strengthen existing surveillance systems to improve the quality, accuracy, and timeliness of morbidity and mortality diabetes data for such populations.

''(d) DEFINITION.—For purposes of this section, the term 'minority population' means a racial and ethnic minority group, as defined in section 1707.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as are necessary for fiscal year 2010 and each subsequent fiscal year.''.

Subtitle C—HEALTH RESOURCES AND SERVICES ADMINISTRATION

SEC. 631. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.

Part P of title III of the Public Health Service Act, as amended, is amended by adding at the end the following new section:

''SEC. 399V. PROGRAMS TO EDUCATE HEALTH PROVIDERS ON THE CAUSES AND EFFECTS OF DIABETES IN MINORITY POPULATIONS.

''(a) IN GENERAL.—The Secretary, acting through the Director of the Health Resources and Services Admin-

istration, shall conduct and support programs described in subsection (b) to educate health professionals on the causes and effects of diabetes in minority populations.

''(b) PROGRAMS.—Programs described in this subsection, with respect to education on diabetes in minority populations, shall include the following:

''(1) Making grants for diabetes-focused education classes or training programs on cultural sensitivity and patient care within such populations for health care providers.

''(2) Providing funds to community health centers for programs that provide diabetes services and screenings.

''(3) Providing additional funds for the Health Careers Opportunity Program, Centers for Excellence, and the Minority Faculty Fellowship Program to partner with the Office of Minority Health under section 1707 and the National Institutes of Health to strengthen programs for career opportunities within minority populations focused on diabetes treatment and care.

''(4) Developing a diabetes focus within, and providing additional funds for, the National Health Service Corps Scholarship program to place individuals in areas that are disproportionately affected by

diabetes and to provide health care services to such areas.

''(5) Establishing a diabetes ambassador program for recruitment efforts to increase the number of underrepresented minorities currently serving in student, faculty, or administrative positions in institutions of higher learning, hospitals, and community health centers.

''(6) Establishing a loan repayment program that focuses on diabetes care and prevention in minority populations.''.

Subtitle D—ADDITIONAL PROGRAMS

SEC. 641. RESEARCH, EDUCATION, AND OTHER ACTIVITIES.

Part P of title III of the Public Health Service Act (42 U.S.C. 280g et seq.), as amended, is further amended by adding at the end the following section:

''SEC. 399W. RESEARCH, EDUCATION, AND OTHER ACTIVITIES REGARDING DIABETES IN MINORITY POPULATIONS.

''(a) RESEARCH AND OTHER ACTIVITIES.—

''(1) IN GENERAL.—In addition to activities under sections 317U and 434B, the Secretary shall conduct and support research and other activities with respect to diabetes within minority populations.

''(2) CERTAIN ACTIVITIES.—Activities under paragraph (1) regarding diabetes in minority populations shall include the following:

''(A) Through the National Center on Minority Health and Health Disparities, the Office of Minority Health under section 1707, the Health Resources and Services Administration, the Centers for Disease Control and Prevention, and the Indian Health Service, establishing partnerships within minority populations to conduct studies on cultural, familial, and social factors that may influence health promotion, diabetes management, and prevention.

''(B) Through the Indian Health Service, in collaboration with other appropriate Federal agencies, coordinating the collection of data on ethnic and culturally appropriate diabetes treatment, care, prevention, and services by health care professionals to the American Indian population.

''(3) PROGRAMS RELATING TO CLINICAL RESEARCH.—

''(A) EDUCATION REGARDING CLINICAL TRIALS.—The Secretary shall carry out education and awareness programs designed to in-

crease participation of minority populations in clinical trials.

''(B) MINORITY RESEARCHERS.—The Secretary shall carry out mentorship programs for minority researchers who are conducting or intend to conduct research on diabetes in minority populations.

''(C) SUPPLEMENTING CLINICAL RESEARCH REGARDING CHILDREN.—The Secretary shall make grants to supplement clinical research programs to assist such programs in obtaining the services of health professionals and other resources to provide specialized care for children with type 1 and type 2 diabetes.

''(4) ADDITIONAL PROGRAMS.—Activities under paragraph (1) regarding education on diabetes in minority populations shall include providing funds for new and existing diabetes-focused education grants and programs for present and future students and clinicians in the medical field from minority populations, including for the following:

''(A) For Federal and State loan repayment programs for health profession students within communities of color.

''(B) For the Office of Minority Health under section 1707 for training health profession students to focus on diabetes within such populations.

''(C) For State and local entities to establish diabetes awareness week or day every month in schools, nursing homes, and colleges through partnerships with the Office of Minority Health under section 1707 and the Health Resources and Services Administration.

''(b) DEFINITION.—For purposes of this section, the term 'minority population' means a racial and ethnic minority group as defined in section 1707.

''(c) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as are necessary for fiscal year 2010 and each subsequent fiscal year.''.

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